DOCUMENT RESUME

ED 077 635 RC 007 063

AUTHOR	Harrison, Ira E.
TITLE	The Migrant Papers. Behavcrial Science Working Paper.
INSTITUTION	Pennsylvania State Dept. cf Health, Harrisburg.
REPORT NO	BSWP-72-3
PUB DATE	Feb 72
NOTE	79p.
EDRS PRICE	MF-$0.65 HC-$3.29
DESCRIPTORS	Community Attitudes; *Crew Leaders; Cultural Factors; *Migrant Health Services; *Migrant Workers; *Negroes; *Program Evaluation; Tables (Data)
IDENTIFIERS	*Pennsylvania

ABSTRACT

Four papers pertaining to health services fcr East Coast migrant workers are included in this publication. These papers are: (1) "The Crew Leader as a Broker with Implications for Health Service Delivery," (2) "Migrant Health Project with Implications for Health Service Delivery," (3) "Planned Change in a Migrant Health Project," and (4) "Life Style of Migrants on the Season and Their Adaptations to Community Attitudes." The first, a revision of a paper presented at the 30th Annual Meeting of the Society for Applied Anthropolcgy cn April 14-18, 1971, attempts to clarify the crew leader's role in health service delivery. The second paper is an evaluation of Pennsylvania's Migrant Health Project during 1964-1970, with a brief history of the Migrant Health Act. The third paper is a research propcsal submitted for funding tc the Pennsylvania State Department of Health for a migrant health project. The fourth paper, delivered at the Florida International University Migrant Program's Social Education Workshop on February 15-17, 1972, discusses a single agency stream-wide approach for dealing with the multifaceted problems of migrant workers. (NQ)

FILMED FROM BEST AVAILABLE COPY

FEBRUARY, 1972

Behavioral Science Working Paper 72-3

ED 077635

U S DEPARTMENT OF HEALTH
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

RECEIVED
AUG 6 1973
AMSU
E.R.I.C.

THE MIGRANT PAPERS

Ira E. Harrison, Ph.D., M.P.H.
Director
Division of Behavioral Science

RC 007063

PENNSYLVANIA DEPARTMENT OF HEALTH
DIVISION OF BEHAVIORAL SCIENCE
BUREAU OF PLANNING, EVALUATION AND RESEARCH

CONTENTS

1. The Crew Leader As a Broker With Implications for Health Service Delivery

Page 1

2. Migrant Health Project Evaluation

Page 21

3. Planned Change In a Migrant Health Project

Page 35

4. Life Style of Migrants On the Season and Their Adaptations to Community Attitudes

Page 57

INTRODUCTION

When I came to the Division of Behavioral Science in 1968, I was asked "to help out in the migrant health project." I was designated a consultant, and began to see what the project was about. Two observations were quite clear. One was that most of the migrant health staff was white, most of the agricultural migratory farm workers were black, and that communication was a problem. The other observation was that the migrant staff knew very little about the life style of migratory farm workers, and were quite frustrated in their attempts to deliver quality health services to them.

In an attempt to deal with the first observation, I suggested that black migrant health aides be used to act as a liaison between the migrant health staff and migrant workers. In Adams County, the county with the largest number of migrant workers, this was successfully achieved. Other counties encountered recruiting and organizational problems, and the utilization of health aides seldom got beyond the talking stage.

In 1969, we received a research contract from the United States Public Health Service to study the life styles of agricultural migratory workers traveling from Florida to Pennsylvania. In an attempt to learn how migrants view health services in order to make changes in our migrant health project, we placed two former black migrants into the Atlantic East Coast Stream in 1969. Their purpose was to provide us with information as to why migrants use or do not use health services, and to describe their life style. In 1970, I received a fellowship to the Johns Hopkins School of Hygiene and Public Health while completing the research report. The report, <u>The Pickers</u>: Migratory

Agricultural Farm Workers' Attitudes Toward Health, was completed during my first quarter at Hopkins.

I began the paper, The Crew Leader As a Broker With Implications For Health Services Delivery, during the second quarter at Hopkins. It is an outgrowth of Chapter XII in The Pickers, "The Crew Leader: An Agent of Change or Control." This paper is an attempt to clarify the crew leader's role in the delivery of health services. I conclude that if health services are viewed as improving the migrant's plight, crew leaders are not interested, unless health services enable crew leaders to maintain control over migrants.

During the third quarter at the School of Hygiene and Public Health, Dr. Zachary Gussow, Anthropologist; Dr. Thomas Wan, Sociologist; and Mr. Jean Romain, Sanitarian Engineer, decided to join me in an evaluation of the Pennsylvania Migrant Health Project as a class project. The result of the evaluation was that the project's goals are achieved given the resources marshalled to achieve the complex task of providing health services to migratory agricultural farm workers. The lack of adequate bookkeeping is a barrier to a more definitive evaluation of the project's effectiveness.

During the fourth quarter at Hopkins, I began the paper Planned Change In a Migrant Health Project. The original paper was the term paper for a course in planned change. Since that time, I have received comments and suggestions from Dr. Thomas Wan, Assistant Professor of Sociology, Cornell University, and Mrs. Janice Reiner, Assistant Professor of Social Planning, University of Puerto Rico, Rio Peidras, Puerto Rico. This research proposal is an outgrowth of the therapeutic migrant aide discussed in The Pickers. It attempts to build migrant's

trust and utilization into the existing health delivery system in Pennsylvania, provide migrants with a visible alternative to migratory farm work, and to establish the therapeutic migrant aide position as an entry level position in the health careers. The proposal is under consideration for funding.

The paper, Life Styles of Migrant on the Season and Their Adaptation to Community Attitudes, is my most recent suggestion for possible long term improvement in the plight of migrant workers. It suggests that current piece-meal migrant projects frustrate staff more than serve migrant clients. A single agency stream wide approach is needed to deal with the multifaceted problems of a severly abused group of people.

As an anthropologist and a behavioral scientist with the Pennsylvania migrant health project, I have had the support and cooperation of many persons. Foremost, I am indebted to the Pickers, the agricultural migratory farm workers, who are an important part of the Commonwealth's economy.

The discussions of Dr. A. L. Chapman, Migrant Health Project Director, Harry Dyblie, Migrant Health Project Administrator, Maria Matalon, Field Coordinator of the Migrant Health Project, and Gail Friendvalds, Supervisory Nurse in Adams County, and her staff have contributed immensely to thoughts in several of these papers.

The suggestions of Thomas Wan, Janice Reiner, Dorothy Nelkin, Helen Safa, and Sol Levine have been very helpful in the clarification and presentation of several ideas.

I am indebted to Miss Jeanette Cohen, and Mrs. Elaine Koester for library assistance, Miss Nancy E. Lagerman for typing, and my wife, Diana, for proofreading and critique.

THE CREW LEADER AS A BROKER

WITH IMPLICATIONS FOR HEALTH SERVICE DELIVERY

BY

Ira E. Harrison, Ph.D.*
Department of Behavioral Sciences
School of Hygiene and Public Health
The Johns Hopkins University
615 N. Wolfe Street
Baltimore, Maryland

A revision of a paper delivered at the 30th Annual Meeting of the Society for Applied Anthropology, Miami, Florida, April 14-18, 1971.

*Post-doctoral Fellow and Consultant to the Pennsylvania Migrant Health Project

THE CREW LEADER AS A BROKER

WITH IMPLICATIONS FOR HEALTH SERVICE DELIVERY

Ira E. Harrison
Pennsylvania Department of Health

Although statistics (Warner 1967: 5-6; Johnston & Lindsay 1965; Gilbert and Schloesser 1963: 990-992; Paige & Smith, n.d.) indicate that health of migrants is poor, attempting to use health and medical services is often not a clear and distinct value, as it can be psychologically painful. Migrants shy away from medical services because they are afraid of being sent to jail, they lack funds, they are refused services when it is not clinic hours, and because of the manner in which physicians treat them.[1] Physicians are sometimes rough when treating them, and demeaning when addressing them, which is consistent with Koos' study, They Follow The Sun (1957), and is implied in Warner's report (1967). Attitudes toward migrants in the communities bordering migrant camps were those of ignorance, indifference and rejection.[2] We found that the crew leader is the only link between migrants and the grower, and between migrants and the larger community, and that he is rather indifferent in urging migrants to use health services. It is this finding that we will explore in this paper.

Although Browning and Northcutt state in their study "On The Season" that "....intensive efforts to reach crew leaders with health education would be fruitful; through them the thousands of migrants who are dependent upon them could be aided" (1961: 61), we question the value of such efforts.

Koos states that "Health and welfare activities for migrants are

often viewed with suspicion by migrants, crew leaders, and growers." It violates the rugged individualistic values of the farmer and crew leader and may be viewed as spying into their labor management practices. (1957: 9) Our data indicates that crew leaders are agents of control, rather than agents of change. Health education activities are activities geared to changing migrants, while keeping migrants isolated from health and welfare activities would help crew leaders maintain control. When OEO workers in Pennsylvania tried to recruit migrants for education and training classes, a crew leader forbade his workers to talk with them. He told our worker, an old friend of his, that the programs are a bunch of foolishness. He brought his crew up the road only to pick fruit, and to make money for him. His men are there to pick apples. He wants all the trees skinned by November 15, and after that he will be taking his people back to Orlando, Leesburg and Winter Garden, Florida.

Although migrants are dependent upon the crew leader, the crew leader is more dependent upon the growers, but he must maintain a position between both groups. He is not a marginal man in the sense that he is a cultural hybrid due to marriage, migration or education in the tradition of Park (1928) and Stonequist (1937), but a marginal man in that he is a product of a marginal situation (Antonovsky 1956). It might be added that at the macro level, migrancy itself is a marginal subculture. Migrants are marginal men (Nelkin 1969: 375); they may be seen as the contemporary end product of the slave plantation and share-cropping systems. And not insignificantly, each had their type of foreman, or crew leader.

Today's crew leader is a product of agricultural farm migrancy, and is subject to various constraints and limitations in his position between grower and migrant. Thus, it is important to understand the role of the

crew leader and its implication for change in the organization of health services.

The Crew Leader As A Broker

Crew leaders may be seen as "brokers" between the migrant workers and the growers. By "broker" I mean that crew leaders are "groups of people who mediate between community oriented groups which operate primarily through national institutions." (Wolf 1936: 1074) Wolf uses the term broker to emphasize the social ties between the shifting arrangements of various social groups in Mexico from Post-Columbian to Post-Revolutionary times, (1958: 1065-1076). He states that the brokers' function is "to relate community-oriented individuals who want to stabilize or improve their chances, but who lack economic security and political connections, with nation-oriented individuals who operate primarily in terms of the complex cultural forms standardized as national institutions, but whose success in these operations depends on the size and strength of their personal following." (58: 1076) Brokers are marginal men whose role is to secure and maintain an adequate labor supply. This is difficult as migrant crews are not permanent year round work units, but are formed seasonally.

Migrant workers may be viewed as community oriented groups in that they are agricultural laborers, primarily ex-share croppers, who have left the rural southern communities in order to work and live in Florida (Perch 1953: 34; Kleinert 1969: 145; Koos 1957: 13; Browning and Northcutt 1961: 5) They left their former communities in Georgia, Alabama, South

Carolina, Mississippi, and other southern states because there was no work, and call Florida home because this is where they now live when they are not "on the season."[3] They are "on the season" because there is no work for them in Florida between May and October.

The growers are nation-oriented groups in that their supply of migrant workers is determined by such extra-community forces as the fluctuations in the agriculture-business markets, weather, farm technology, and labor leglislation (Schwartz 1945: 17-25). This orientation is extra-community as some growers are members of agricultural associations which own large farms and operate several labor camps in the Atlantic Coast Migratory Stream. Such farms are called "chain farms" (Gillian 1946: 39). For example, one of our field workers worked for D. D. Jones, a crew leader who worked for Erwin Smith, a grower, who owned several farms in Florida and Virginia. D. D. Jones takes his crew to Camp Bravo, Virginia, and then back to Florida. When his truck drivers haul tomatoes, cucumbers, and potatoes to the grader, the driver must wait until Erwin Smith's name is called. Then the truck loads are recorded in his name. Jones travels in an oasis-like pattern from Smith's Florida camp to Smith's Virginia camp. Smith is a member of a grower's association. Growers associations have contracts with hotels, motels, restaurants, food chains and the Federal Government for fruits and vegetables and are supra-locally organized.

One of the functions of these associations is to deliver crops when the price is favorable, and to withhold crops when prices are not favorable. The crew leader as a broker is illustrated in our field notes, when there was a market for crops during the last week in June, and the first week in July, but a drop in the market during the following weeks.

Our field notes read:

> Erwin Smith...was a slave master. He would always be on Mr. Jones' back complaining about the crew. 'D.D. those people are being lazy. I want you to have them pick at least 1,000 baskets a day. I am paying 60 cents a head.' Erwin Smith never commented on a job well done. Even when the migrants picked 8,000 baskets of tomatoes in a week, Erwin Smith never commented on that. Erwin Smith and D.D. work his crew on the 4th of July all day long. Early in the morning Erwin Smith came to the field and said to D.D., 'Sure is hot boy, (D.D. is 55 years of age) but D.D. get those tomatoes today. I won't see you till tomorrow, we're having a cook-out today. The old lady has got some guests, have to be to the house today. See you.' D.D said, 'Yes, we intend to work all day long.'

The crew worked from 6 a.m. to 5 p.m. on July 4th, from 6 to 6 on July 5 and 6. The market was good, the crops were in demand, but later on in July, the market was unfavorable and our field notes read:

> Today we only worked a half day. We were knocked off by Mr Erwin Smith....the market dropped on tomatoes and they were only going to pay the migrants 15 cents a basket. This dropped the migrant down 5 cents. We had been picking for 20 cents a basket so Mr. Smith told D.D. to have the people just to pick 500 baskets and knock off. So we picked 500 baskets and we knocked off by 11:30. We all returned to the camp a lot of weary people, torn and tired, disgusted because we had been unable to make any money this week. All the work that we got this week was one full day and two half days.

During the latter part of July in 1969, an informant in the Cape Charles area of Virginia told me that there had been only two and one-half days work for some weeks. "There is no market and these farmers are plowing under potatoes, tomatoes, and cucks." As we drove along U. S Highway #13 on Virginia's Eastern Shore, we saw migrants in camp areas, and acres and acres of scorched cabbage. Our informant exclaimed: "The farmers won't let them (migrants) touch them...there's no market." We drove over to the grader and the packing houses. We

saw trucks loaded with potatoes, but no drivers. The trucks were waiting for orders to roll.

At the Monkville camp, in Pennsylvania, we have an example of praise and pause, as a grower, Paul Miner, tells the crew leader, Jim Huntley, that his crew has done well, but not to pick anymore tomatoes that week. Our field notes read:

> He (Paul Miner) said that he was a very happy man and he was very pleased to have each and everyone working for him. He came by to let them (migrants) know that they had picked a total of fifteen thousand (15,000) baskets of tomatoes. He said he told Mr. Huntly and his crew that so far as he was concerned they were the outstanding group so far in this part of the county (Northumberland). Mr. Miner did not want the people to go to work on Saturday because they would be unable to pull the tomatoes out of the field until early Monday morning. They had picked in three fields the entire week and...the men he has to load (the trucks) were pretty slow in loading. There were too many tomatoes out there to go to the market until the first thing Monday morning. He told Mr. Huntley that his people could have off all day Saturday and all day Sunday. He did not want them to come out to the field until 12 o'clock that Monday. The migrants were very happy and very pleased with this.

Here the grower regulates the number of tomatoes picked, loaded and marketed. If the price had been right, the migrants and loaders would have been working Saturday and Sunday to harvest and haul Miner's tomatoes, with crew leader Huntley in command.

Thus, the crew leader may be seen as a broker to insure growers an adequate labor supply (Perch 1953: 72), and to help insure migrants "top dollar" (Kleinert 1968: 53). Perch states that the crew leader institution "represents the only permanent security for many workers." (1953: 71. This may be changing as the demand for migrants change with increasing use of farm technology (Schulman 1968), and the Federal

Government's attempts to provide educational and job-training programs for migrants. Gilliam states that the role of crew leader served to stabilize the supply of migrant workers for the growers (1946: 7) and this illustrates Wolf's concept of "broker." The crew leader works primarily for the growers, and not the migrants.

The crew leaders' responsibility in Florida is different from his responsibility "on the season." In Florida, the crew leader sends his trucks and buses to pick up migrants daily, supervises them in the fields and provides them with lunches. The crew size and personnel changes as the prices fluctuates with market conditions, which means that crew leaders seldom know their workers, and workers seldom know for whom they are working. The farmer or grower records the migrant's time, pays him, and provides transportation and medical care when a worker is injured. Thus, in Florida, the crew leader is a labor contractor providing farmers with employees for whom he has very little responsibility.

"On the season," the labor contractor becomes a leader of a crew of pickers who migrate from farm labor camp to farm labor camp, up and down the Atlantic East Coast Stream picking tomatoes, potatoes, cucumbers, and beans as they ripen. He recruits, transports, supervises, pays and evaluates his crew, most of whom are the same people. The grower recruits mechanical equipment operators, records the work done, and pays the crew leader, who pays the crew. The growers' concern is for the crops and his equipment, and he leaves the supervision of the work and the workers to the crew leader. Stewart states that, "Most growers...abdicate all management functions of the work relationship

either to a vacuum or to the crew leader." (1968: 108) This makes the crew leader the most powerful person in the migrant community as he must provide work, food, housing, transportation and recreation for his pickers.

The crew leader not only works for the grower, but also works for himself. The crew leader controls his workers by credit, force, fear of force, favors, kinsmen, and their own ignorance. Few migrants can read. Most of the time they do not know the name of the farmer for whom they are working or how much they are being paid. They are just paid. Breakfast ranges from $.85 to $1.00 a plate and dinner ranges from $1.00 to $1.50 a plate. Luncheon sandwiches cost $.35 to $.50 a sandwich and sodas cost $.20. Rent varies from $3.00 a week for single migrants to $6.00 a week for married migrants. One crew leader purchased cigarettes for $2.37 a carton, and sold them for $.50 a pack. He purchased wine for $1.00 a bottle, and charged $2.00 cash or $2.50 credit. This crew leader wore a pistol, and fired his rifle every day. When a migrant tried to walk away to another camp, a crew leader saw him, and beat him brutally with one hand, while wielding an axe in the other hand, in full view of the crew. No one stopped him, or tried to assist the injured migrant. The crew leader's stepfather in still another crew charged $.25 and $.50 for trips into the city from the camp. An average picker might make $60.00 during a good week, however, there are few good weeks, and the crew leader always takes his food, rent, wine, beer, whiskey, and cigarette money first. If one of the few women on camp say that one of the men owes her money, she is paid also, before the picker gets his money. This means that most migrants are in debt to the crew leader by the end of pay day. Most crew leaders permit their crew a free ride to

town on Saturday afternoon, but they are back on camp by evening. Our female worker drove a 1962 Pontiac. She was told by crew leaders in Virginia and Pennsylvania that she was not to ride migrants in her car. If there was anything migrants wanted or needed, they could supply it.

Crew leaders provide transportation to medical facilities when it is convenient for them. Crew leaders are reluctant to transport injured migrants because it interferes with their field supervision, recruiting efforts or sleep. The only time a crew leader insisted on a migrant visiting the health facilities was when he suspected one of his females had venereal disease and was infecting the crew. Failure to see that she and the infected men were treated meant a limited work force, and possible trouble with the grower and health officials. Most crew leaders were indifferent to health services, as most migrants were on their own after work hours.

Crew leaders were referees to many fights on labor camps. In two fights in Pennsylvania, the crew leader forbade men to fight with sticks, but made them fight with fists, and made them stop before either man was injured badly. In a neighboring camp, it is rumored that a migrant was knocked unconscious in a fight, and the crew leader ordered some men to carry him to his shack to have him sleep it off. When he did not appear the next morning for breakfast, they found him where they had left him. At the hospital, he was pronounced dead on arrival. Had he arrived there right after the fight, he might have been saved. Crew leaders are interested in well, able bodied individuals who can take it, and not the soft, weak or injured.

Although I have used the generic term crew leader, or contractor, I have referred to the Afro-American, or Black crew leader, and not Puerto Rican, Mexican-American, or other ethnic crew leaders.[4] We must take a look at the cultural background of the area and the relationships of its people in order to understand the source of authority of the black crew leader.

The Source of Authority of the Black Crew Leader

Pearsall in discussing the plantation culture of the southeastern region of the United States says that "....before the present trend to mechanization, diversifications, and an urban cosmopolitan way of life, all segments of the population were essentially folk people. Separate and different as they were, they lived intimately with each other in a small and personal world. Neighbors were "our kind of folks" and the other subgroups were ours, too - "our Negroes" or our white folks," "our workers" even "our poor whites." (1966: 138) This is the background from which migrants may be viewed as the out growth of the slave-plantation system, and the share-cropper system.

Bryce-Laporte calls the slave-plantation system a total institution in that it rendered the black slave totally dependent upon the white community and, therefore, it was anti-community as far as black identity, cohesion, or control was concerned. He states "....the planter class enjoyed the privilege of decision-making and determining if, how, and where, they (and their slaves) would settle. The slaves could merely settle. They had no choice. Their presence was decided by others and their patterns of living were in large part passive reactions to the

policies of the planters and their surrogates." (1969: 6) During slavery, a crew leader would have been a surrogate called a driver. A driver was a Negro who went with each group of slaves "to secure the utmost labor." (Hunter 1922: 5) The driver worked under the overseer, who was the buffer between the planter and the slave. Overseers were primarily poor whites who aspired to become planters. They were "usually ignorant, high-tempered, and brutal." (Hunter 1922: 5) There role was to please the planter, to control the labor force slaves and to harvest a good crop. How they accomplished this was oft-times left to them.

However, Herskovits states that: "Planters learned early in the use of slave labor that it was necessary to give certain trusted Negroes limited authority over the others so that with a change of overseers the plantation routine might be disturbed as little as possible. On the large plantations the seasoned Negroes trained the new ones and were responsible for their behavior. In the early days of the plantation regime, when a gang of fresh Africans were purchased, they were assigned in groups to certain reliable slaves who initiated them into the ways of the plantation. These drivers, as they were called, had the right of issuing or withholding rations to the raw recruits and of inflicting minor punishment." (1958: 132)

The driver, as surrogate, was used as a stablizing agent for the plantation system. Slaves were provided work, food, clothes, and medical care. All profits from slave labor went to the slave master and their surrogates.

After the Civil War, a sharecropper system (crop-lien tenant)

relationship replaced the slave-plantation system as a new form of accomodation between ex-masters and ex-slaves. This system provided cheap laborers for the planter in exchange for food, shelter, and credit, as the black share cropper had no capital. The sharecropper "rented" farm land from the white landowner who in turn provided all the necessary equipment. The landowner kept records of all advances (goods, clothes, medicine, etc.) to the sharecropper. When the crop, usually cotton, was harvested, the landowner collected his rent and his profit or "interest" in the form of harvested cotton. The excess cotton owned by the sharecropper was also sold by the landowner on the behalf of the sharecropper. The tenant was given his net earnings in exchange for credit toward next year's expenses. If paid in cash, the amount received by the sharecropper was so small that he was soon in debt to the landowner. In bad years, the landowner transferred some of the losses to the tenant. (Vandiver 1966: 25) The planter kept all records, and he could cheat the sharecropper because he had the law on his side and few sharecroppers could read or write. This, plus the operation of a plantation store on extended credit, and interest rates of up to 25 percent at times, meant that the sharecropper, or tenant was anchored to the landlord.

The Civil War destroyed the farmer planter-slave holding class. The postwar planter-landlord class emerged as brokers. They found themselves in debt to northern banking interests and industrial speculators. Former slaves provided the labor, and northern business provided the capital to exploit the agricultural south in the reconstruction era. They were anchored between the Northern Capitalism on the one hand, and a Southern Traditionalism on the other hand. A tradition that said blacks must be kept ignorant, dependent and powerless.

The sharecropper system was similar to the slave-plantation system as master-slave relationships became landlord-tenant relationships. These dominant-dependent relationships gave the majority of blacks little or no opportunities to learn how to read or write, to calculate indebtedness, to learn how to use money, to learn how to accept scientific medical treatment, and to share in shaping their own destinies. As slaves, blacks were provided medical care because they were expensive property, but as former slaves they were left on their own to develop sickness awareness, health seeking habits, curing practices, and practioneers. This resulted in the reliance on folk medicine, and voodoo, as most blacks could not afford the cost of contemporary medical care. (Harrison and Harrison 1971) If the slave-plantation system was a total institution, the sharecropper system was almost a total institution. The sharecropper could share in the losses of the planter during a season, but he had little legal or economic power to alter his status. This system discouraged thrift and consistency of behavior habits which are necessary for self-improvement (Dollard 1949:120). This system served to realign the former master-slave accommodation.

The Depression of the 1930's and World War II were the major forces disrupting the sharecropper system. The demand for sharecroppers was low during this depression, and the Federal Government, via the Agricultural Adjustment Administration, had to rescue both landlord and sharecropper. Landlords were able to receive payments for acreage restriction, soil conservation, and soil banks, and were able to cheat sharecroppers out of their payments, (Vandiver, 66: 27). This shift from the sharecropping system to the Federal payment of planter-landlord and tenant-sharecropper altered crop-lien arrangements. The planters were cheating their workers,

were not providing for "his Negroes," and the hostility and mistrust that this caused, increased the demise of the crop-lien system. World War II created a demand for unskilled labor in the Northeast and the West, and over one million blacks left the South.

It is against this background that we must see the rise of the black crew leader. The crew leader is concerned with control not change. Historically, the black crew leader was recruited by white "...managers and farm placement representatives in consultation with Negro ministers, civic leaders, local office personnel, and those who had been previously selected and were functioning as crew leaders." (Milton 1950:31) Crew leaders were given black and yellow arm bands of honor, posters and stickers for their cars and trucks, and business cards as indicators that they were surrogates of State employment agencies to organize local workers into crews. Black crew leaders arose as brokers between local black workers who had lost the security of work under the sharecropping system, and the State employment service representing the planters, who lost an adequate supply of cheap labor under the sharecropping system. He became the semi-surrogate of the nation-oriented dominant planter group between a subordinate migrant group of individuals who left rural folk communities.

VI. Implications for Change

Thus, black migrants are the ancesters of Southern folk who:

1. Have little or no formal education. Therefore, they cannot read, write, or tell time. The implications for health are they cannot read medical instructions, and are somewhat resistant to the idea of taking medicine at regular intervals. For example, Maud is illiterate

and was given douche pills which she took internally, and became ill. This happened not only because pills (sulfa) for her kidney infection and her douche pills may have been similar in color and size, but also because they were pills, and one usually swallows pills. That incident occurred in Pennsylvania. In Florida, Bessy said, "I went down to the clinic to see the doctor. He give me birth control pill but they make me plenty sick. I throw them away. Damn those things. That damn doctor think I'm crazy, me ain't tho. Us find some other way to keep from children." She is 28 years old; has 11 children living, 4 dead; and no regular husband.

2. Have little or no understanding of the value of money because they have been dealt with in credit, and lack experience in pricing and selective shopping. The implications for health are that the fee-for-service system of medical care is beyond the means of most migrants. They must rely on a benefactor, welfare, or go without medical care. For example, Willie Lee removed 11 stitches from his forehead because he did not have the money to return to a physician in Virginia.

3. Have little or no understanding of scientific medicine and modern health seeking practices, and therefore, rely on information and treatment passed on from parents, relatives and friends. Pat used hot water and peroxide for her cut foot in Virginia and Pennsylvania, but finally went to the clinic in Pennsylvania. Pat heard from Ada, the pregnant migrant, that the Pennsylvania doctors and nurses treated her well. She went to the clinic and got well. Judge, a white migrant, used vanishing cream on his cuts and bruises and kept a hacking cough. He would not seek medical aid because, "People would laugh if you went to the doctor for a cold!"

4. Have little or no opportunity to participate in community decision making processes in order to decide their own fate, and therefore depend upon white leaders or their surrogates for cues and direction.

Therefore, attempts to bring changes rests with the very people who might be exploiting them. The implication for health is that when growers and farmers are convinced that health education and care of migrants is in their best interests, migrants' knowledge of and use of health care facilities will increase.

This may be valid, but its likelihood is remote. Providing health care and information is not the responsibility of the crew leaders. The crew leader as a broker is only obligated to bring growers and workers together and to control the migrants. Controlling migrants oft-times means keeping them isolated from the immediate village or town. This is no problem for the crew leader as he or members of his family are usually the only persons with cars. This physical isolation results in psychological isolation, which reinforces the authority and control of the crew leader. Therefore, attempts to reach migrants and change their illness behavior and health seeking behavior may require a subversion of the broker role of the crew leader, or the creation of a new broker role for a migrant health specialist in camp or en route, with the grower's sanction. Rosenstock (1966) suggests that people do not use health services unless they are psychologically ready, unless the action is perceived to be feasible, appropriate, beneficial, there are no psychological barriers, and that there is some stimulus to trigger the action. A migrant health specialist could function in such a role, and also help to reduce fear and distrust of health officials.

VII. Summary

Our data does not support Browning and Northcutt's thesis that crew leaders would be helpful in reaching migrants for health services. The crew leader is a broker between migrants and farmers and growers' associations. All crew leaders with whom we had any contact or any information about are migrant exploiters and make most of their money from their control over the illiterate migrants. Thus, the crew leaders would have little interest in improving the plight of the migrant workers. Therefore, another strategy is needed. A migrant health specialist in camp might work if sanctioned by the grower.

NOTES

[1] In an attempt to learn how migrants view health services in order to make changes in our migrant health projects, we placed two former (one male; one female) black migrants into different crews in the Atlantic-East Coast stream in 1969. They worked as migrant workers, observing and recording migrant life styles and illness behavior. Their purpose was to observe what happened when migrants are sick or injured, and to provide us with information as to why migrants use or do not use health services. This study was made possible by a research contract from the Health Services and Mental Health Administration of the Department of Health, Education, and Welfare.

2. A white community investigator traced the route of our field workers from Florida to Pennsylvania interviewing 33 key local officials (sanitarians, nurses, law enforcement officers, clergymen, newspaper editors, etc.) in an attempt to ascertain various services available to migrants and the communities' attitudes toward migrants. It was felt that community attitudes might affect migrants' utilization of health services.

3. "On the season" is a term used by migrants to designate seasonal farm work.

4. Lucien E. Forster uses Wolf's concept of the culture broker in his unpublished Master's thesis: Cultural and Economic Mediation Among Spanish Speaking Migrant Farm Workers in Dade County, Florida. University of Miami, 1970.

REFERENCES CITED

Antonovsky, A.
1956 Toward Refinement of the Marginal Man Concept. Social Forces. 35:57-62.

Browning, R.H. and T.J. Northcutt
1961 On the Season. Florida State Board of Health. Monograph No. 2.

Brumback, C. L. and D.N. Logsdon
1966 Palm Beach County Health Department Migrant Project, MG11C (66), U.S.P.H.S., West Palm Beach, Florida.

Bryce-LaPorte, Roy Simon
1969 The American Slave Plantation and Our Heritage of Communal Deprivation. American Behavioral Scientist. 12:2-9.

Dollard, John
1949 Caste and Class in a Southern Town, New York: Doubleday Anchor.

Gilbert, Arnold and Patricia Schloesser
1963 Health Needs of Migrant Children in a Kansas Day Care Program. Public Health Reports. 78, 11:989-993.

Gilliam, Curtis B.
1946 The Atlantic Coast Agricultural Migrant in North Carolina, United States Employment Service.

Harrison, Ira E. and Diana S. Harrison
1971 The Black Family Experience and Health Behavior. In Health and the Family. Charles O. Crawford, ed. New York: MacMillan Press. pp. 175-199.

Herskovits, Melville J.
1958 The Myth of the Negro Past. Boston: Beacon Press.

Hunter, Frances
1922 Slave Society on the Southern Plantation. The Journal of Negro History. VII January 1-10.

Johnston, Helen L. and J. Robert Lindsay
1965 Meeting the Health Needs of the Migrant Worker, Hospital, 39:78-82.

Kleinert, E. John
1968 The Preliminary Report of the Florida Migratory Child Survey Project. Florida Migratory Child Survey Center, Miami: University of Miami.

Koos, Earl L.
1957 They Follow the Sun, Florida State Board of Health. Jacksonville: Florida Health Monograph No. 1.

Milton, V.A.
1950 Citation of Merit for Job Well Done. Employment Security Review. 17:31-33.

Nelkin, Dorothy
1969 Aspects of the Migrant Labor System, New York State School of Industrial and Labor Relations. Cornell University, Ithaca, N.Y.

Paige, David M. and Karen F. Smith
Migrant Farm Workers and Society: A Crises. Mimeograph, Johns Hopkins University School of Hygiene and Public Health.

Pearsall, Marion
1966 Cultures of the American South. Anthropological Quarterly. 39:128-141.

Perch, Louis
1953 An Analysis of the Agricultural Migratory Movements on Atlantic Seaboard and Socio-Economic Implications for the Community and the Migrants, 1930-1950, Unpublished Doctoral Dissertation.

Rosenstock, I.M.
1966 Why People Use Health Services. Milbank Memorial Fund Quarterly, XLIV: 3, 2, July.

Schulman, Sam
1968 The Future of Migrants. Eastern States Migrant Health Conference. Orlando, Florida, March 26-28.

Schwartz, Henry
1945 Seasonal Farm Labor in the United States. New York: Columbia University.

Steward, Judith
1968 An Examination of the Social Boundaries of the Migrant Labor System on the Atlantic Coast Stream, an unpublished Master's Thesis, Cornell University.

Stonequist, Everett
1937 The Marginal Man. New York: Scribrers Publishing Co.

Vandiver, Joseph S.
1966 The Changing Realm of King Cotton. Trans-Action. 4:24-30.

Warner, Lisa
1967 The Health of the Migrant in Eastern Suffolk County: Seasonal Employees in Agriculture Incorporated. Migrant Conference.

Wolf, Eric R.
1956 Aspects of Group Relations in a Complex Society: Mexico, American Anthropologist. 58:1065-1078.

MIGRANT HEALTH PROJECT EVALUATION

I. Introduction: The Pennsylvania Department of Health's Migrant Project

Ira E. Harrison, Ph.D.

II. The History of the Migrant Health Act

Zachary Gussow, Ph.D.

III. The Aims and Objectives of the Pennsylvania Migrant Health Project

Ira E. Harrison, Ph.D.

IV. The Evaluation of the Pennsylvania Migrant Health Project

Thomas Wan, Ph.D. and Jean Romain, BSCE

V. Movie: Forgotten Families: Migrant Families and Health Care

PENNSYLVANIA MIGRANT PROJECT EVALUATION

I. Introduction to the Pennsylvania Department of Health's Migrant Project

by Ira E. Harrison

This presentation is an evaluation of the migrant health project of the Commonwealth of Pennsylvania's Department of Health. I will open our presentation with a brief background statement on why the project was instituted. Zachary Gussow will discuss the National Migrant Health Act as a response to the problems of such states like Pennsylvania. I will then discuss the aims and objectives of the projects through the years, and the services rendered in order to achieve them. Thomas Wan and Jean Romain will evaluate the medical, health, and environmental health services. Finally, we will close our presentation with a part of the movie: Forgotten Families: Migrant Families and Health Care. This movie adds visibility, vitality, and variability to our presentation as we attempt to acquaint you with the real world about which we speak.

Annually, between May and October, about 8000 agricultural migratory farm workers move through the state of Pennsylvania. About 75 per cent of these migrants are Southern blacks from Florida, Georgia, and Alabama, about 23 per cent are Puerto Ricans, and the remainder are Mexican American and Southern whites. Most migrants are males in the age group 15-44 years of age. Migrant workers and their families pick potatoes, tomatoes, mushrooms, apples, cherries, peaches, beans, tobacco, and strawberries in 33 of Pennsylvania's 67 counties. The demand for migrant labor is greatest in the southeastern and south-central sections of the state: the most urbanized area and the fruit bowl of the state.

According to the 1970 State Department of Labor and Industry Report:

> "For the first time in history, Pennsylvania farmers received more than a billion dollars from the sale of their produce in 1969. Approximately 7,500 migrant farm workers in Pennsylvania helped to make this possible through their efforts in harvesting the fruit, vegetable, mushroom and tobacco crops produced during this year. (1970:7)

There is little question as to the value of the migrant worker, especially when the crops are ripe. However, medical and health services for migrants have been questioned and closely examined.

Before Title III of the 1962 Public Health Services Act was amended, other than the traditional tuberculosis and venereal disease control and child care, there was little or no organized health service for migrant workers and their families. Health and medical services for acute respiratory infections, back strain, intestinal parasites, accidents, etc., were available only on an emergency basis. Most physician's and hospital bills were left unpaid, placing a tremendous burden on the limited number of physicians and hospital facilities in rural areas. There was great concern about the financial burden that these "outsiders" placed on the local health resources, and a search was begun to remove this burden from rural health services.

Zachary Gussow will now give the legislative history of the National Migrant Health Act as one solution to this problem for rural areas. It provides grants to states like Pennsylvania for migrant health project and for projects like those we will see in the movie Forgotten Families.

II. History of the Legislation (Public Law 87-692, 87th Cong., 1962)

by Zachary Gussow

The Migrant Health Services bill was passed on September 25, 1962 as an amendment to Title III of the Public Health Services Act. It authorized grants to public and other nonprofit agencies, institutions and organizations for paying part of the costs of establishing, operating and improving family health service clinics for domestic agricultural migratory workers and their families (of which there are about 1 million), and for the training of personnel to operate these clinics.

There were no major changes in the content of the bill until 1970 at which time the legislation was modified to include seasonal agricultural workers (the local rural poor) and to broaden community participation in the development and implementation of programs in the long-term effort to assist communities put together the fragmented pieces of existing community health services.

From the outset the objectives of the bill have both been diffuse and have undergone significant changes in interpretation. Initially, the program was designed to raise the health status of domestic agricultural migratory workers and their families to that of the level of the general population in the U.S. This was to be achieved by increasing health care opportunities for migrant workers at the rural level and by developing a system for the continuity of care.

With elaboration and differentiation new objectives have now emerged which are recognizing that future farm technology may come to replace migrant labor. Consequently there is recognition of the need for developing ways to integrate migrant workers into community life.

Faced with programs whose objectives are diffuse and programmatic, the evaluator is confronted with a different (and more complex) kind of task than in situations where goals and objectives are stated clearly at the outset. The evaluator's task is complicated by the fact he must clarify the objectives, order them in terms of priorities and foresee the various contigencies that are involved.

MIGRANT HEALTH SERVICES BILL
Public Law 87-692, 87th Congress (1962)

FEDERAL FUNDS ALLOCATED
FOR STATES (in millions $)

1963 -- 1	1966 -- 7	1969 -- 13	1971 -- 20	1974 }	increases
1964 -- 1	1967 -- 8	1970 -- 15	1972 -- 25	1975 }	proposed
1965 -- 1	1968 -- 9		1973 -- 30		

III. The Aims and Objectives of the Pennsylvania Migrant Health Project

by Ira E. Harrison

The aims and objectives of the Pennsylvania Migrant Health project has changed as staff became more aware of migrant health problems and could provide the necessary services.

The aims and objectives of the project from 1963-66 were:

1. To provide general outpatient medical and health services to seasonal migrant workers, their families and dependents who may be presenting complaints.
2. To collect a body of definitive medical and health related information which may later be translated into facts for program planning purposes.
3. To develop the most economic method of providing a continuing program of meeting minimal emergency medical and health needs.
4. To continue to test and evaluate professional medical and community attitudes toward expansion and continuation of this or a similar program on a statewide level.
5. To evaluate the extent to which family health services clinics located in areas of high migrant population density have encouraged workers to seek treatment of incipient conditions thereby minimizing the onset and development of disabling and crippling complications.

The services to achieve these aims and objectives were:

A. Family health clinics
B. Nursing services
C. Sanitation services
D. Hospital services
E. Private physicians "in lieu thereof" clinics

The 1966 aims and objectives were basically the same but re-defined a little more specifically in the following areas:

1. To provide outpatient health and medical services to Pennsylvania migratory workers and their dependents through family clinics established in local hospitals and through these services, the illnesses and disabilities of migrant may be detected sooner and brought to the attention of physicians for treatment.
2. To provide a system of preventive health services to migrants through the use of public health nurses who will work with migrants in their camps. Their efforts will be bolstered by the use of health educators in regional offices supervised by a full-time health educator on the central staffs.
3. To improve the system of inspecting migrant camps and housing facilities to insure a safe water and food supply, adequate sewerage and garbage disposal and provide protection from insects and rodents.
4. To continue the accumulation of data that will identify unmet health needs of migrants and assist in the evaluation of services rendered.
5. To provide in selected areas on a pilot basis routine prophylactic and treatment services to migrants having central problems.

The services were virtually the same as before with the addition of dental services.

The aims and objectives were the same as in 1966 in 1967-68, with the expansion of emergency dental services throughout the project area on an emergency basis and the dilection of hospital care. Migrants were found to be eligible for Medical Assistance under Title XIX in the Department of Welfare

The services were virtually the same, however, nursing assistants were hired for the first time to aid the nurses and more sanitarians were employed.

There were very little changes in the aims and objectives from 1968-1970. Service wise, there was the addition of a behavioral scientist in 1968 as a consultant and the use of former migrant workers as migrant health aides in 1969.

IV. The Evaluation of Migrant Health Project

by Thomas Wan and Jean Romain

This is a report of an evaluation of migrant health projects in Pennsylvania during the past seven years, 1964 through 1970. The study was undertaken to attempt to answer the following questions:

1. Can effort be made for improving medical care and maximinizing the utilization of available health services by migrant farm workers and their dependents?
2. If so, can it be determined with reasonable certainty which programs remain effective and which become ineffective?
3. If these two questions can be answered, what are the degree of success or failure encounted by the programs in reaching predetermined goals?
4. What alternatives can we propose for facilitating more proper and efficient programs for migrant farm workers and their dependents?

The first question was answered affirmatively that health services have been already put into place to meet the urgent needs for migrant farm workers and their dependents during their staying in Pennsylvania. Table 1 presents input and output components of migrant health project. It is postulated that the incidence of diseases found among migrants who visited clinics varies with the amount of efforts being devoted in the health services. It is found that the proportionate number of patient visit and clinical attendance, the clinic hours provided by hospital, and the budgets spent in sanitarians, in-hospital care and dental care are directly correlated to incidence of clinical

diagnoses among outpatient visits of migrants. The evaluation of this project focuses on quantity of services provided for migrants. However, the qualitative aspects of health services will be unable to ascertain from the reports of Migrant Health Project prepared by the Department of Health in the State of Pennsylvania. Moreover, the effectiveness of the programs, which may be measured from the patients' performance (improvement of health level), is determined by the frequency of clinical findings and diagnoses for outpatient visits. One crucial assumption has to be made that proper treatment and referrals to in-hospital care for those migrants who have been screened and diagnosed with diseases were made in each year. Thereby, the end-effect (output) which we are trying to evaluate is incidence of clinical diagnoses found among migrants. In general, most of health programs administered in Pennsylvania were very successful in terms of promoting utilization of health services. The analysis of cost components for migrant health project is made in Table 3 which indicates more budgets were provided for health services in later years.

The program objectives have been graduately moved from secondary into primary prevention. However, the effort made by educational programs has not been able to overcome certain problems in this health project. It is always desirable to provide efficient services if we know migrants' urgent needs. Home visits and follow-up are necessary for health project if enough health manpower will be recruited for each project area.

The overall goal of the Pennsylvania Migrant Health Project has been achieved successfully during seven project years. It is our view that more better systems of record-keeping should be established in order to provide sufficient information for evaluation.

TABLE 1. PERCENT AND NUMBER DISTRIBUTIONS BY SELECTED INPUT AND OUTPUT FACTORS FOR MIGRANT HEALTH PROJECTS IN PENNSYLVANIA, 1964-1970

Migrant Health Project	1964	1965	1966	1967	1968	1969	1970	Mean	Standard Error
Input:									
Patient Visit %	18.0	20.7	28.7	31.4	38.1	37.5	41.2	30.8	3.4
Visits referred by P.H. Nurse %	80.0	77.3	71.9	67.0	44.0	53.7	53.7	63.9	5.2
Adult (15-44 years) %	90.0	62.0	66.0	50.0	58.0	69.8	60.7	65.2	4.8
Male %	78.0	78.0	80.0	71.0	75.0	78.0	69.3	75.9	1.5
Average Duration of Staying(week)	18	18	20	22	15	14	11	16.9	1.4
Blacks %	80.4	76.0	74.7	80.7	75.0	75.0	75.0	76.7	1.0
Clinical Attendance %	18.0	20.7	18.3	20.2	24.3	20.1	25.6	20.4	.9
Clinic Hours (hour)	247	247	247	249	233	568	569	337	59.8
Budgets for Projects									
Nursing %	27.3	22.0	27.0	19.0	29.5	26.5	26.6	25.4	1.4
Sanitarians %	6.1	6.0	4.0	4.0	10.9	10.7	10.4	7.4	1.2
Hospital and Physician Services %	9.2	15.0	16.0	14.2	11.8	11.4	11.6	12.7	.9
Bus Transportation %	8.8	14.0	15.0	10.6	10.3	5.4	6.7	10.1	1.3
Drugs and Supplies %	5.4	6.0	6.0	2.4	2.0	2.0	3.1	3.8	.7
Dental Care %	-	-	5.0	4.1	3.3	3.4	4.8	2.9	.8
In-Hospital Care %	-	-	-	22.5	15.4	24.8	24.2	12.4	4.5
Administrative and Personnel %	43.2	37.0	27.0	23.2	17.8	15.8	12.6	25.2	4.3
Sanitation Index for Uncorrected Defects %	7.7	16.3	27.6	32.1	23.0	9.5	19.0	19.3	3.4
Output: Clinical Findings*									
All Conditions %	17.5	19.8	24.2	47.3	40.2	36.3	34.0	31.3	4.2
Infective and Parasitic %	1.8	2.3	1.2	2.3	4.1	3.0	3.5	2.6	.4
Respiratory %	3.2	5.9	4.5	6.2	9.3	7.3	8.1	6.4	.8
Digestive %	2.2	.8	3.8	1.3	2.4	9.3	3.0	3.3	1.1
Accidents %	1.4	2.5	2.8	4.2	5.5	3.7	6.3	3.8	.7

Note: * Medical conditions found among outpatients of migrant farm workers.

The measurement of relationship between environmental characteristics and health levels of migrant workers in the state of Pennsylvania raises the following two problems: (1) Since migrants reside only for a short term in the camps each year, it is difficult to separate morbidity due to the life prior to living in the camps from the experiences resulted from the present environmental hazards in camps; and (2) the lack of precise criteria for measurement of environmental components and health levels of migrants make such research still more problematic.

The input data of sanitation in this study are derived from a composite index using 5 components currently estimated in the camps, i.e., water, sewage disposal, garbage and refuse, food handling, insects and rodents control. Equal weight was given in the composite index to these components. The index is a quotient of the difference between the number of defects found during inspections and the number of corrections made divided by the total number of camps being inspected. However, in some cases, when these components were not available, an estimate of the index was made by the number of camps having defects which were not improved divided by the total number of camps being inspected.

The degree of association between sanitation index and the output data may be seen in Table 2. There is a positive association between the sanitation index and all clinical findings; that is the poorer the sanitary conditions, the more frequent out-patient visits were referred to and, therefore, more diagnoses were made.

In the light of this finding we would like to make the following suggestions: (1) This statistical finding does not imply causal relationship but rather statistical association between poor sanitary

TABLE 2. CORRELATION MATRIX OF INPUT AND OUTPUT VARIABLES FOR EVALUATION OF MIGRANT HEALTH PROJECT IN PENNSYLVANIA, 1964-1970

	1 All clinical findings	2 Infective & Parasitic diseases	3 Respiratory diseases	4 Digestive diseases	5 Accidents	6 Patient visit	7 Visits referred by P.H. nurses	8 Adult	9 Male	10 Average duration of staying(week)	11 Blacks	12 Clinical attendance	13 Clinical hours	14 Nursing	15 Sanitarians	16 Hospital and Physician services	17 Bus transportation and travel	18 Drugs and supplies	19 Dental care	20 In-hospital care	21 Administrative and personnel	22 Sanitatinn(index)
1	1	.56	.68	.16	.72	.75	-.70	-.72	-.59	-.06	.04	.32	.22	-.23	.29	.03	-.36	-.90	.63	.85	-.76	.59
2		1	.93	.14	.81	.73	-.88	-.38	-.52	-.73	-.37	.62	.42	.32	.88	-.41	-.56	-.77	.19	.67	-.68	-.07
3			1	.18	.89	.85	-.92	-.64	-.50	-.62	-.53	.63	.41	.19	.77	-.07	-.38	-.77	.43	.71	-.83	.19
4				1	.06	.44	-.40	.22	.33	-.41	-.43	-.05	.69	.37	.48	-.24	-.57	-.38	.31	.42	-.47	.41
5					1	.91	-.86	-.66	-.76	-.59	-.41	.79	.47	.15	.62	-.06	-.39	-.73	.67	.77	-.89	.38
6						1	-.93	-.54	-.53	-.61	-.53	.62	.64	.27	.68	-.09	-.52	-.80	.79	.85	-.92	.26
7							1	.44	.40	.65	.53	-.49	-.49	-.43	-.83	.24	.52	.84	-.56	-.75	.89	-.12
8								1	.53	-.09	.22	-.44	-.01	.46	-.01	-.60	-.21	.45	-.55	-.50	-.59	-.79
9									1	.31	-.18	-.79	-.32	.27	-.24	.15	.39	.52	-.40	-.66	.51	-.36
10										1	.59	-.70	-.78	-.58	-.92	.53	.68	.39	-.15	-.46	.56	.48
11											1	-.35	-.42	-.52	-.54	-.25	-.03	.06	-.38	-.09	.53	.03
12												1	.65	-.04	.53	-.09	-.42	-.37	.35	.60	-.60	.06
13													1	.19	.65	-.34	-.78	-.45	.37	.68	-.65	-.38
14														1	.59	-.49	-.26	-.05	.10	-.10	-.19	-.39
15															1	-.57	-.71	-.63	.13	.57	-.63	-.43
16																1	.79	.35	.30	-.25	.00	.70
17																	1	.68	-.12	-.73	.48	.52
18																		1	-.46	-.92	.79	-.13
19																			1	.58	-.81	.62
20																				1	-.86	.14
21																					1	-.30
22																						1

conditions of camps and high incidence of clinical diagnoses; (2) Supplementary insight by means of epidemiological investigations is necessary but cannot be ascertained without improvement in quality of sanitary data collected; (3) More skilled sanitarians are needed for continuous rather than episodic inspections of camps.

TABLE 3. ESTIMATION OF COST COMPONENTS FOR MIGRANT HEALTH PROJECTS IN PENNSYLVANIA, 1964-1970

(Dollars)

Components of Health Project	1964		1965		1966		1967		1968		1969		1970	
	pc	pc/py	pc	pc/py	pc	pc/py	pc	pc/py	pc	pc/py	pc	pc/py	pc	pc/py
Health Services	6.2	16.6	7.5	20.3	11.3	27.0	19.1	41.7	27.4	86.5	23.4	80.4	25.8	110.7
Nursing	2.9	7.9	2.6	7.0	4.1	9.7	4.7	10.3	9.7	30.7	7.4	25.3	7.9	33.6
Sanitarians	.7	1.8	.8	2.1	.7	1.7	1.2	2.6	3.6	11.3	3.0	10.2	3.1	13.2
Hospital& Physician	1.0	2.7	1.8	4.8	2.5	5.9	3.5	7.6	3.9	12.2	3.2	10.9	3.4	14.7
Bus Transportation	.9	2.5	1.7	4.5	2.3	5.5	2.6	5.7	3.4	10.7*	1.5	5.2	2.0	8.5
Drugs and Supplies	.7	1.8	.7	1.9	.9	2.1	.6	1.3	.6	2.0	.5	1.9	.9	3.8
Dental Care	-	-	-	-	.8	1.9	1.0	2.2	1.1	3.5	.9	3.2	1.4	6.1
In-Hospital Care	-	-	-	-	-	-	5.5	12.0	5.1	16.0	6.9	23.6	7.1	30.6
Administrative	4.5	12.1	3.9	10.2	3.5	8.4	5.4	11.6	5.4	17.1	4.4	14.8	3.7	15.7
Total	10.8	28.7	11.4	30.5	14.7	35.4	24.5	53.3	32.8	103.6	27.8	95.2	29.5	126.4

Note: PC= per capita
PY= per person-year

* Bus transportation and travel greatly overestimated this project year.

Estimation of PC is based on the quotient of total budget for a specific item divided by total number of migrant farm workers in a period of time. Estimation of PC/py is derived from the following procedures:

(1) no. of migrant workers x average duration of staying(year);
(2) total budget for a specific item; and
(3) quotient of (2) divided by (1).

SOURCES

Annual Progress Report: Health and Medical Services for Seasonal Agricultural Workers Project Grant MG-33, United States Public Health Service, Pennsylvania Department of Health, Bureau of Planning, Evaluation and Research 1964-1970.

Hearings Before the Subcommittee on Migratory Labor of the Committee on Labor and Public Welfare, United States Ninetieth Congress, S 2688, Dec. 7, 1967. Washington: U.S. Government Printing Office.

Lectures and Consultations on Evaluation by Matthew Taybeck, Sc.D., Public Health Statistics #4, School of Hygiene and Public Health, Baltimore: The Johns Hopkins University. February-March, 1971.

Pennsylvania Migratory Labor Program Report: The Governor's Committee on Migratory Labor, 1969, 1970. Harrisburg: Department of Labor and Industry.

Requested Data on Migrant Health Projects 1963-1970, Bureau of Planning, Evaluation and Research. Harrisburg: Pennsylvania Department of Health. 1971.

Schupert, Herbert et. al.: Program Evaluation in the Health Fields, New York: Behavioral Publishing Co. 1969.

The Migratory Farm Labor Problem in the United States, 1969 Report of the Committee on Labor and Public Welfare, United States Senate. February 19, 1969. Washington: U.S. Government Printing Office.

United States Public Health Service: Migrant Health Program Conference for Eastern States Report. Orlando, Florida. March 25-28, 1968. Arlington, Virginia.

World Health Organization Expert Committee on the Public Health Aspects of Housing. WHO Technical Report Series Number 225. WHO, Geneva, 1961.

World Health Organization: Occupational Health Problems in Agriculture. WHO Technical Report Series Number 246. WHO, Geneva, 1962.

World Health Organization: National Environmental Health Programs: Their Planning, Organization and Administration. WHO Technical Report Series Number 439. WHO, Geneva, 1970.

MIGRANTS AND HEALTH CARE: A SELECTED BIBLIOGRAPHY

Browning, R. H. and T. J. Northcutt
1961, On the Season. Florida State Board of Health. Monogram Number 2.

Brumback, C. L. et. al.
1961, Eating Patterns Among Migrant Families. Public Health Reports 76, 4:349-359.

Faricy, Lois J.
1966, A Selected Bibliography: Health and Culture of Spanish Speaking Migrant Labor. Department of Sociology-Anthropology, Colorado. Reprinted by the U.S. Public Health Service.

Gilbert, Arnold and Patricia Schloesser
1963, Health Needs of Migrant Children in a Kansas Day Care Program. Public Health Reports 78, 11:989-993.

Harper, George L.
1969, A Comprehensive Care Program for Migrant farm workers. Public Health Reports 84, 8:690-696.

Harrison, Ira E.
1970, The Pickers: Migratory Agricultural Farm Workers' Attitudes Toward Health. The Pennsylvania Department of Health, the Pennsylvania Health Council, and the U.S. Public Health Service.

Johnston, Helen L.
1968, Goals of the Migrant Health Program. Eastern States Migrant Health Services. United States Public Health Service.

_____ and J. Robert Lindsay
1966, The Health of the Migrant Worker. The Journal of Occupational Medicine, 8:27-30.

_____ et. al.
1961, Health Needs of Seasonal Farm Workers and Their Families. Public Health Reports, 76, 6:469-474.

Koos, Earl L.
1957, They Follow the Sun. Florida State Board of Health. Jacksonville, Florida. Health Monogram Number 1.

Paige, David M. and Karen F. Smith
n.d., Migrant Farm Workers and Society: A Crises. Mimeograph. Johns Hopkins University School of Hygiene and Public Health.

Peterson, Paul Q.
1967, Migrant Health Future Outlook. Western States Migrant Health Conference. Los Angeles, California.

Siegel, Earl
1964, Health and Day Care for Children of Migrant Workers. Public Health Reports, 79, 10:847-852.

PLANNED CHANGE IN A MIGRANT HEALTH PROJECT

Ira E. Harrison, Ph.D., M.P.H.
Director
Division of Behavioral Science
Bureau of Planning, Evaluation and Research
Pennsylvania Department of Health

A Research Proposal Submitted for Funding

Planned Change In A Migrant Health Project

by Ira E. Harrison, Ph.D., M.P.H.

The primary goal of this proposal is to follow through on a goal of an earlier study of Migrant Health Attitudes and Practices: to improve health services for farm migrant workers in Pennsylvania through the Pennsylvania Department of Health. (Harrison, 1970)

I. The Nature of the Problem

Annually, about 8,000 agricultural migratory farm workers and families move through the state of Pennsylvania between May and December. About 75 percent of these are Southern blacks from Florida. The remaining 25 percent are Puerto Rican, Mexican American and Southern whites.

The Pennsylvania migrant health project is a jointly funded study of the United States Public Health Service and the Commonwealth of Pennsylvania, coordinated by the Pennsylvania Department of Health's Bureau of Planning, Evaluation and Research, and administered at county level in 21 of the state's 67 counties by public health nurses.

Physicians and nurses in the Pennsylvania migrant health project (MPH) complain that migrants do not use health facilities when they are provided, or having once begun treatment, fail to return for follow-up treatment. (Migrant Health Reports 1964-1966) This is a puzzling, and frustrating problem to many public health workers who attempt to provide quality health care for migrant workers. Thus, the morale and efficiency of dedicated public health professionals are eroded and endangered when migrants do not accept the sick role. This in turn affects the professional-client relationship and the delivery of health services.

In an attempt to learn how migrants view health services, an investigation was therefore made by placing two former black migrants into the

Atlantic-East Coast Stream in 1969. They worked as migrant workers. This provides an opportunity for them to observe what happened when migrants are sick or injured, and to record information as to why migrants use or do not use health services.

In addition to the two black field workers (one male and one female), a white community investigator traced the route of our field workers from Florida to Pennsylvania interviewing 33 key local officials (sanitarians, nurses, law enforcement officers, clergymen, newspaper editors, etc.) in an attempt to ascertain various services available to migrants and the Communities' attitudes toward migrants. It was felt that community attitudes might affect migrants' utilization of health services.

To get a fuller picture of migrants' attitudes and practices towards health, sickness, birth and death, the following were interviewed: three migrant health project physicians in Pennsylvania, four migrant health physicians in Florida, three migrant health physicians in Virginia, three crew leaders in Florida, five migrants in Florida who were sick while in the stream, eight migrants who were trying to leave the stream through an OEO program, two Florida school teachers, a Florida pharmacist, and a Florida mortician.

In Pennsylvania, migrant camps are visited by a public health nurse, public health assistant, or a migrant health aide. Aides are a recent addition to the staff, and work in the county with the largest number of migrants. Aides are black, and act as a liaison between the white nurse or assistant and black migrant workers. This visiting health team (VHT) visits the camps for sick migrants, makes clinic appointments, and conducts follow-ups on migrants who have previously been to the well baby, family, and emergency dental clinics. The following services are also provided: physicians, sanitation, hospital, emergency, pharmaceutical, laboratory,

and transportation. Fee for service contractual arrangements with physicians and hospital exist where the establishment of clinics is impractical. Project operation extends from June to December.

The Pennsylvania migrant project's health-care delivery system is structured to function once a migrant is registered for clinic. If migrants do not come to the clinic, the system can not treat them. Our problem is to get more migrants into the system, and to get migrants to continue to use the system, once they have begun treatment.

An additional aspect of this proposal is to initiate a mechanism which will move those migrants out of the stream who want to leave the stream into a career in the health profession. This is in line with the idea New Careers for the Poor by Pearl and Riessman (1965). Our research indicates that change on the part of both health professionals and migrants is necessary for professionals to deliver quality care, and for migrants to receive quality care. An opportunity for migrants to move out of the migrant stream and into the health field, which implies trust on the part of migrants and concern on the part of health professionals, is embodied in the therapeutic aide concept developed in this proposal.

Finally, the improvement of health status of migrant workers entails the concern of community wide voluntary and governmental social and welfare organizations. The therapeutic migrant health aide can serve as a change agent for helping these organizations to obtain information about migrants and to program more relevant and specific activities for migrants.

II. Need for Further Study

It was found that migrants do not use health facilities when feeling ill even though health services may be available. They are unaware that they need health care unless they are in pain, or see blood. This finding is consistent with results found by Shafer et. al. (1961:471), Gilbert and

Scholoesser (1963:992), Dougherty (1965:1), and Warner (1967:4).

It was found that migrants are suspicious of health personnel such as physicians who may treat them rough or demean them. This finding is consistent with those of koos (1956:44) and Scott (1967:24).

Another finding was that migrants are isolated from surrounding communities due to the crew leaders' control and growers' neglect (Steward 1968:108; Nelkin 1970:35, 64) and the attitudes of community people near the camps (Dougherty 1965:3; Nelkin 1970:33).

Therefore, it has been observed that migrants do not use health services because (1) they do not know when they are ill, unless they are acutely ill; (2) they are treated rudely and roughly by health personnel; (3) they are isolated from communities, and health services by crew leaders' control, growers' neglect, and community attitudes; (4) they know nothing about the services available, nor how to get the services; (5) those migrants who knew that health services were available, used them, and were disappointed with the medical treatment because they were either personally demeed, or were afraid other migrants would laugh, and consequently treated themselves (Scott 1967:24; Harrison 1970:161-191) and (6) working until acutely ill is done, rather than using health services as a prevention to sickness, as economical considerations are prior to medical attention.

Also, crew leaders are rather indifferent to migrants using health services because they are interested in the well, able bodied individuals who can take it, and not the soft, weak, or infirmed. Crew leaders are reluctant to transport injured migrants because it interferes with their field supervision, recruiting efforts, or sleep (Harrison 1971:12).

It was found, too, that crew leaders knew about the existence of health services, and would send, or take migrants to clinics if they felt

migrants needed treatment.

Thus, lack of knowledge of health clinics, per se, does not seem to be a barrier to utilization of health services, especially in crises situations. The problem appears to be that migrants have not been treated with respect and dignity when they have tried to use health services. They have not had the support of the grower and the crew leader in seeking health care. Migrants have not been prepared for the sick role, or told what to expect, in a positive manner, in the physician-patient encounter. Thus, a lack of trust, rather than a lack of knowledge, is a barrier to health care utilization.

Health personnel usually assume that they have the trust of patients they treat, and that patients trust them. This is not always valid with lower class persons (Suchman 1965:6), blacks (Harrison 1968:9; Harrison and Harrison 1971:193-195), and black migrants are skeptical and suspicious of health personnel. Part of this lack of trust on the part of migrants has been discussed in previous paragraphs, and part of this lack of trust on the part of physicians is due to their underestimation of their patients. Our female worker was stung in the eye by a wasp and relates what happened when she visited the migrant clinic:

> "The doctor said, 'Oh, come on in girl (our worker is in her late forties). What do you need, a shot of penicillin?'
> I said, 'I don't know.'
> The doctor looked at me and said, 'It is usually the same case.'
> I said, 'You haven't let me tell you why I'm here.'
> The doctor said, 'What hurts you?'
> I said, 'Well, nothing too much, my eye. It's my eye. I got stung by a bee, in the field yesterday, and now my eye is beginning to hurt me very bad.'
> The doctor treated me very rough. He pulled by eye open. It pained so bad I hollered at him.
> He said, 'Sorry, nasty sting. I'll put something in it.'
> He put some drops in my eye. Then he bandaged it and said, 'Now I want you to leave this bandage on your eye three days. Come back then. That will be $4.00.'
> He said it all in one breath, 'Next please.'
> This was Dr. _____ of Nassawadox, Virginia---I did not care for Dr. _____'s Treatment, or his attitude toward me."

Physicians' lack of concern for patients, measured by the information they give to patients, is a factor in patient follow through on physician instructions. Pratt et. al. (1966:310) state that patients who received some explanation from physicians about their condition were more likely to ask questions, to agree with the diagnosis, and make plans to comply with physician instructions than patients who did not receive a physician explanation. Therefore, information in the physician-patient interaction may be a crucial factor in the formation of concern and trust, and may encourage patients to follow through on physician instructions.

Rosenstock (1966:99) suggests that people do not use health services unless they are psychologically ready, unless the action is perceived to be feasible, appropriate, beneficial, there are no psychological barriers, and that there is some stimulus to trigger the action. People who perceive that they are vulnerable, and see a means to remedy their vulnerability are more likely to use health services than those who do not perceive themselves vulnerable. If this is valid, then, we could increase migrants utilization of health services by not only making health services physically available, but also by preparing migrants to see their need for health services and by using a new type of health aide as described later on in this proposal.

The evaluation of the current health project is inhibited by the sporadic record keeping. (Harrison et. al. 1971:8). Four outcomes can be seen from the current system: 1. migrants who are cured, and need no further treatment; 2. migrants who die, and need fo further treatment; 3. migrants who move on, and can no longer be treated in the project; and 4. migrants who have begun treatment, drop out and do not return. A concern must be raised for those migrants who begin treatment and drop out before they have been released from the care of health personnel. Milo (1967:1985-1900) demon-

strates that structuring the situation for health activity is crucial for acceptance and utilization among low-income people.

Thus, it is postulated: if a better system of records were developed such that we could tabulate the four outcomes above, and follow-up migrants in these four categories, a better evaluation could be made of migrant health care services.

III. Objectives

It is proposed, therefore, that a strategy be developed to increase migrant's utilization of health services by increasing trust. Conceptually, trust may be viewed as confidence and dependency with varying degrees of mutual empathy and understanding. Operationally, for us, trust is the consequences of interpersonal relations, and health and sickness information. The greater the degree of trust, the greater the utilization of health services. Thus, the better health personnel meet migrants' needs, as defined by migrants; the greater the trust in health personnel and the health delivery system. Therefore, that strategy is a new type of migrant aide; the therapeutic migrant aide.

It has been observed that migrants have attempted to use the VHT as a source of information on clothes, social security, barbers, beauticians, shoe repair, laundromats, churches, nightclubs, addressing envelopes, stamps, and egrings. By handling such requests the therapeutic migrant aide (TMA) can free the VHT for services more directly related to health care.

Migrants asked their field workers in an earlier study to read letters, to write letters, and to help them beautify their shacks (Harrison, 1970). Migrants imitated these workers in beautifying their shacks, washing regularly, using deodorant, and in using prune juice as

a laxative. Meeting these needs in Virginia, Maryland, and Pennsylvania established trust among the migrants. Perhaps this trust can be conceptualized:*

1. I will not hurt you
2. I want to help you
3. I can help you
4. I respect you
5. I will help you

Although the visiting health team (VHT) has enough credibility to enable them to visit camps and identify cases for clinics, this trust is not sufficient to cause migrants to take preventive health action, nor is it sufficient to cause migrants to get the follow-up treatment suggested by health professionals.

Emergency treatment may be an example of the first degree of trust as there is an implicit trust that the physician will not hurt the migrant any more than he is already hurting. The VHT is operation at the first and second degrees of trust. They are not seen as increasing pain, maybe viewed as possibly reducing pain, and maybe seen as tokenly interested in the migrant's well being. In order to move to degrees three, four, and five, it is proposed that a new type of migrant health specialist, a therapeutic migrant aide, (TMA) become a change agent. (See Chart: Comparison of Regular Migrant Aide with Therapeutic Migrant Aide.) It is also proposed that a record system be developed that would permit an evaluation of the utilization of this change agent.

*We are studying ways to operationize and measure "Trust".

Comparison of Regular Migrant Health Aide (RMA) with Therapeutic Migrant Health Aide (TMA)

AGENT	Regular Migrant Health Aide	Therapeutic Migrant Health Aide	
PURPOSE	To identify unmet health needs of migrants, and act as a liaison between migrants and professional staff (physicians and nurses).	To increase health care utilization of migrants, and follow through behavior of migrants until cured, or released.	To be a change agent for migrants
OBJECTIVES	1. To improve communication of migrant health problems to professional staff by visiting camps, and assisting them in health-care facilities. 2. To improve communication of health services to migrants who become patients.	1. To identify unmet health needs of migrants, and act as a liason between migrants, regular migrant aide, and professional staff in camp. 2. To improve communication of migrant health problems to regular migrant aide, and professional staff by living in camp and relating to migrants.	1. To be a model for migrants as an entry-rung on the health care career ladder. 2. To speak to community wide social and welfare organizations about migrant life styles.
TASKS	1. Family Clinic a. Assist in filling out health cards b. Register patients as they arrive c. Take patients to lab and Xray for necessary treatment d. Assist in flow of patients in clinic e. Assist in filling out forms 2. Dental Clinic a. Assist nurse in making appointment for migrants at dentist b. Arrange transportation c. Inform patients d. Remain in dentist office when there is a clinic to assist patients in getting Rx. 3. Child Health Conference a. Assist nurse in clinic preparation and set up b. Assist nurse with children, rotating the children through clinic c. Assist in completing Child Activity Report 4. Office Area a. Maintain list of migrant workers and camps b. Assist with filing of family folders and migrant health information sheets c. Assist in answering phone 5. Special Areas a. Assist in delivering stool containers b. Assist in collecting specimens c. Assist in setting up experimental teaching classes if desired	1. Alert hospital personnel for emergency cases. 2. Transports sick migrants to clinics. 3. Provides clinic and hospital with background of injuries and sicknesses. 4. Relieves the crew leader of requests for information about the local community, and health and medical services. 5. Tells migrants about community services (health, welfare, recreational.)	1. Reminds migrants of opportunities in area wide organizations for migrants who want to leave the stream during the season. 2. Interpretes migrant life style for social and welfare organizations after the season.

A second aide (SA) will be employed in order to evaluate the effectiveness of the TMA. The SA will function similar to the TMA, however he or she will not be a former migrant, but a low income person interested in migrants. This will enable us to see if the role-status of former migrant is more important in establishing rapport and motivating migrants, than the status of non-migrant. Thus, the following hypotheses will be examined:

1. The role-status (position) and expertise (rapport) of the TMA results in more migrants using health services, and more migrants following through on health personnel instructions until cured, or released, than the role-status of the SA, and vice-versa.
2. The role-status (position) and expertise (rapport) of the TMA results in more migrants using health services, and more migrants following through on health personnel instructions until cured, or released, than the role-status of the VHT, and vice-versa.
3. The role-status (position) and expertise (rapport) of SA results in more migrants using health services, and more migrants following through on health personnel instructions until cured, or released, than the role-status and expertise of the VHT, and vice-versa.

The TMA and SA will be quartered in camp prior to the arrival of migrant crews. The TMA's and SA's entry into the migrant community will be sanctioned by the grower to the crew leader. The grower and the crew leader will decide how best to communicate the TMA's and SA's function to the rest of the crew. They will make it clear that the TMA is a member of the State Department of Health Migrant Team and works in

conjunction with the visiting health team. The TMA is to be non-directive in his approach to migrants, exhibiting interest in them generally. He is not to be zealous in health matters. His presence is to indicate an interest in the migrants and their well-being. How he, or she does this is outlined below in a restatement of purposes and objectives with specific tasks.

Purpose: To increase migrants' use of health services and follow through behavior until cured.

Objectives:

1. To be the link in camp between migrants and public health personnel.
2. To be the link in camp between migrants and the neighbors in the communities.
3. To be the interpreting link between migrant life styles and community wide social and welfare organizations.

Task: To establish rapport with migrants by:

1. Identifying with them by saying that I am a former migrant worker, or picker, who used to go "on the season." The implication is that I understand many of your problems.
2. Preparing migrants for clinics, discussing health problems, and making emergency referrals. The implication is that I am here to help you when there is "hurt, harm, or danger."
3. Helping migrants to read and to write letters. The implication is that I am interested in helping you to communicate with those who are interested in helping you, and with whom you are interested in.
4. Exhibiting own living quarters so that migrants might be inspired to imitate the same for themselves. The implication is that you can also arrange your quarters like this, and I will help you.
5. Referring migrants and arranging contacts in the immediate community for information on clothes, shoe repair, barbers, beauticians, laundromats, churches, night clubs, etc. I can help you find things in the community.
6. Referring migrants and arranging contacts in the immediate community for educational and job training opportunities. The implication is that you can leave the stream, after the season, if you want to, and you need not be a picker forever.

7. Showing movies on selected health subjects and cartoons. The implication is that good health can be interesting, entertaining, and educational, as well as crucial to your well being.

Task: To appear before voluntary and involuntary health and welfare organizations during the off season discussing:

1. Migrant community relations - how migrants view the communities surrounding them, how such communities react to migrants. Possible solutions to problems.

2. Migrant housing and camp environment and possible solutions to problems.

3. Migrants as human beings: Who they are, where they come from, what their goals and aspirations are, what their problems and needs are, and possible solution to problems.

4. Migrant Health: Issues, problems and possible solutions.

These aides will keep diaries of daily events for background data on the subject. This will help us identify unmet health needs, and give us data on the temporal-spatial occurrences of accidents and injuries and lay referral systems in various crews. This diary will also include complaints that migrants have about their work, the camp, the crew, the clinic, other migrants, their lives, etc. This material will be useful for community organizers who are interested in organizing migrants, for health advocates and for migrant consultants.

V. Evaluation

Our model of planned change is based on the assumption that a TMA will increase trust on the part of migrants about the health-care delivery system. This will result in more migrants using the health-care delivery system, and more migrants returning for follow-up treatment. The change assumes that the TMA will be more effective than the current visiting health team, and is an evaluation of that team.

We select three homogeneous (age-sex composition; ethnicity; crew origin, crew size, length of residence) camp areas in the same county. The TMA and the SA will be quartered in two of the camps and the VHT will

visit all three camps, and others as they have in the past. A record system will be established to collect the following data:

1. Name, number and ethnicity of migrants in all camps
2. Name, number and ethnicity of migrants using clinics in all camps
3. Time of day
4. Date of the month
5. Weather conditions
6. Age
7. Sex
8. Occupational status
9. Educational level
10. Language
11. Marital status
12. Individual medical history
13. Family medical history
14. Home address
15. Number of rooms in dwelling unit
16. Number of persons living in dwelling unit
17. Water: hot, cold; inside, outside
18. Toilet: inside, outside
19. Shower or Bath: inside, outside; private, shared
20. Refrigeration
21. Local address
22. Number of persons living in your room
23. Medical complaints in migrants' terminology
24. Migrants' complaints in medical terminology
25. Referred to clinic by whom

26. Treatment given

27. Follow up

28. Attending physician

29. Attending nurse

30. Name of crew leader

31. Name of grower

32. Lay referral system

This registration system will give us the basic data to test the preceeding hypotheses by computing a paired t-test for the significance of difference in the means of migrant utilization rates and follow-up rates among the camps. (See appendix 2. Research Design.) The research period will last three years with data collected on individual migrants in each camp and tabulated and collated on a monthly bases. These aides will receive the same training and orientation.

VI. Use of Findings

Any program suggesting change in the existing system is bound to meet some resistence. Watson (1969:496) states: "A major problem in introducing social change is to secure enough local initiative and participation so the enterprise will not be vulnerable as a foreign-importation." We were aware of this and suggested the idea of the therapeutical aide to the supervisory nurse in the county in which we want to employ its use, as well as her public health nurse, assistant, and regular migrant health aide. They gave their approval of the TMA, suggested two camps and growers who might be favorable disposed toward having the TMA in their crew. They even suggested the type of person to select for a TMA:

Age: 25-35

Sex: Female

Race: Black

Marital Status: Married, Single, or Divorced

Education Background: High school, or less

Other information: Former migrant; drivers license

They felt that the TMA will greatly facilitate their work in the camps and would free them for medical matters and record keeping. They saw only one problem, supervision. Supervision is being worked out and ought not to be a problem after the period of orientation and training. We appreciate the support of the county nursing staff, however, we need the committment of others if we are to be successful in increasing the utilization of health services for migrant workers. These others are support agents and agencies. They, their committment, and their rewards are outlined on the following page. This is the non zero sum strategy where the clients (migrants) and everyone else get committed, are rewarded, and still continue to do what they like to do.

IX. Summary

In summary, we attempt to increase migrants' utilization of health services in Pennsylvania by employing a demonstration project which builds migrants' trust in the existing health delivery system. We will do this by employing a therapeutic migrant health aide. This aide will also act as an experimental group in the evaluation of the existing health delivery system (the control group.) Another aide will be employed as the second experimental group and will help to compare the TMA's and VHT's effectiveness. A new record system will be instituted to evaluate the performance of these aides.

The primary goal is an increase in migrant's utilization and follow-up of health services. A secondary goal is the identification of unmet health needs. Our objectives are an evaluation of the existing

SUPPORT SYSTEM

Agent or Agency	Commitment	Rewards
Grower	a. Acceptance of the Therapeutic Migrant Aide (TMA) and the Second Aide (SA) on his camp b. Introduction of these aides to crew leader	a. Prestige of aiding scientific research b. Possible deterrent to destruction of camp property c. Healthier work force d. Freedom from providing for the sick
Crew Leader	Introduction of these aides to the crew	
State Department of Health	a. Employment of Therapeutic Migrant Aide and Second Aide, as entry positions on a career ladder in the health field b. Supervision, training, and evaluation of TMA and SA	a. New source of health manpower b. Evaluation of existing health delivery system c. Promotion of more efficient migrant health delivery system d. Removal of low-income persons from welfare rolls and poverty level
Local Health Personnel		
A. Physicians	a. Sensitivity training in migrant life style b. Discretionary explanation to migrant patients about the nature of their illness	Promotion of quality health
B. Nurses, Assistants, Aides, etc.	Acceptance of supervision and training of the TMA and SA as a staff member	a. New source of staff help to free current staff for more pressing concerns b. Prestige of training new health workers

SUPPORT SYSTEMS, Continued

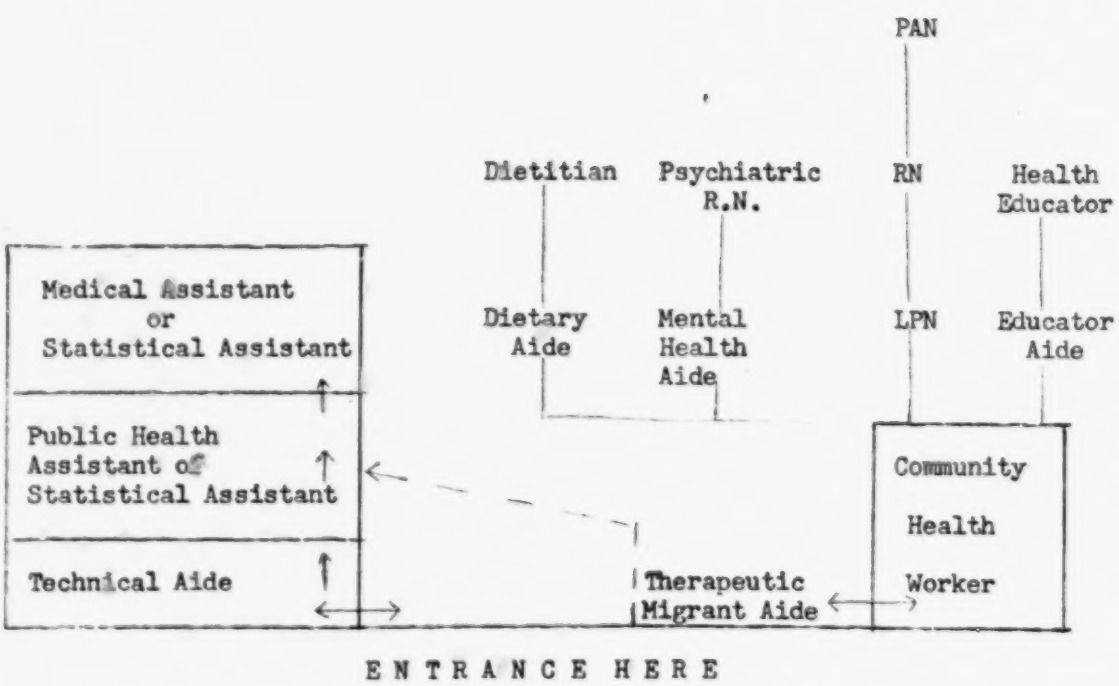
Agent or Agency	Commitment	Reward
Local Community		
A. Office of Economic Opportunity Staff	a. Recognition of the value of cooperation rather than competition with health teams in camp areas b. Refraining from visiting camps to solicit migrants for educational and manpower training services unless invited by growers or health staff	a. TMA, SA, and other health staff will collect basic information on crews and migrants which will be useful to OEO staff b. TMA and SA will direct upwardly mobile migrants to OEO staff
B. Local Neighbors	Recognition of the value of cooperation and the chronicling of information through the TMA and SA	The coordination of community efforts at camp level facilitating precision, dispatch and congeniality.

health delivery system, and a stragety which moves low income persons out of poverty by creating entry positions into the health profession.

We intend to apply what we learn in this project on health delivery systems in the Commonwealth of Pennsylvania, and the nation. The long range goal is better health for migrant families, and the larger community of which the migrant workers are a marginal but actual part, by socializing the migrants into proper utilization of the health delivery system.

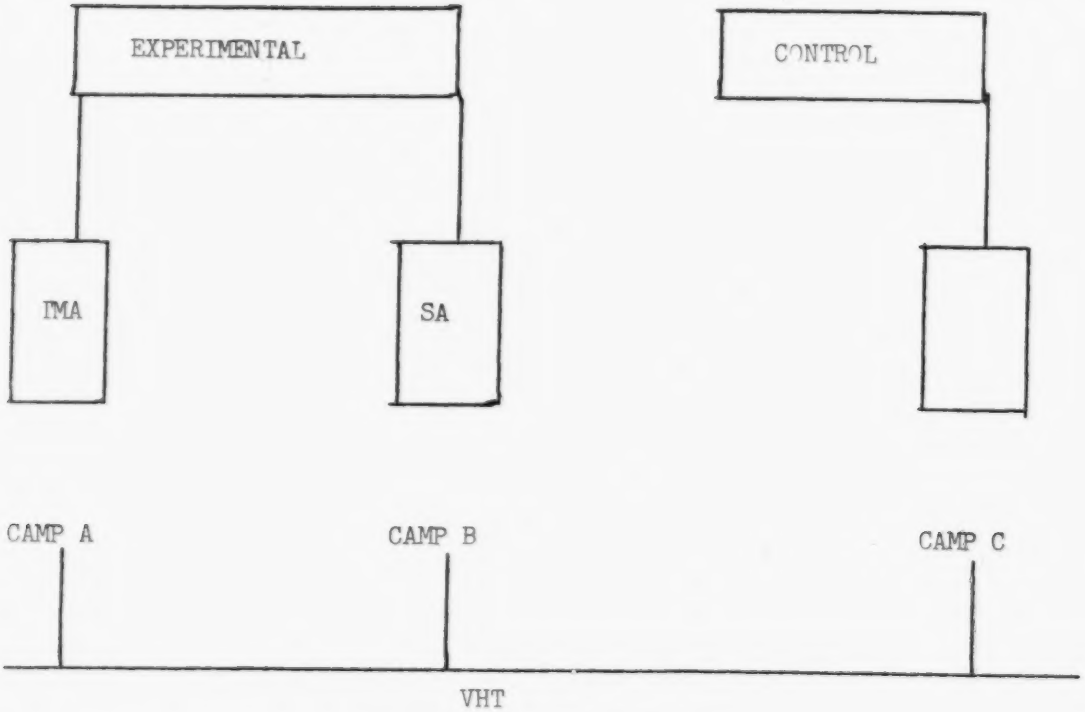
Appendix A

Career Ladder Into Health Professions



Appendix B

RESEARCH DESIGN



PUBLIC HEALTH NURSE
PUBLIC HEALTH ASSISTANT
REGULAR MIGRANT HEALTH AIDE

BIBLIOGRAPHY

Dougherty, William J.
1965 Health Needs of Migrant Workers. New Jersey State Department of Health.

Gilbert, Arnold and Patricia Schloesser
1963 Health Needs of Migrant Children in a Kansas Day Care Program. Public Health Reports 78, 11:989-993.

Harrison, Ira E.
1968 Observations in a Black Neighborhood Clinic. Division of Behavioral Science. Pennsylvania Department of Health, Harrisburg, Pennsylvania

_____
1970 The Pickers: Migratory Agricultural Farm Workers' Attitudes Toward Health. The Pennsylvania Department of Health. The Pennsylvania Health Council, and the U.S. Public Health Service.

_____
1971 The Crew Leader As A Broker With Implications for Health Service Delivery. Paper read at the 30th Annual Meeting of the Society for Applied Anthropology, Miami, Florida.

_____ and Diana S. Harrison
1971 The Black Family Experience and Health Behavior. In Health and the Family. C. Crawford ed. New York, Macmillan.

_____ et. al.
1971 Migrant Health Project Evaluation. Typewritten.

Koos, Earl L.
1957 They Follow the Sun. Florida State Board of Health, Jacksonville, Florida Health Monograph No. 1.

Milo, Nancy
1967 Structuring the Setting for Health Action. American Journal of Public Health 57, 2:1985-1999.

Nelkin, Dorothy
1969 Aspects of the Migrant Labor System
New York State School of Industrial and Labor Relations
Cornell University, Ithaca, New York.

Pearl, Arthur and Frank Riessman
1965 New Careers for the Poor. New York, The Free Press.

Pratt, Lois et. al.
1965 Physicians' Views On the Level of Medical Information Among Patients. In Medical Care. W. R. Scott and E. H. Volkart eds. New York, Wiley & Sons, Inc.

Rosenstock, I. M.
1966 Why People Use Health Services. Milbank Memorial Fund Quarterly XLIV 2, 3:94-127.

Scott, Clarissa
1967 Those Who Remained: A Study of Seasonal Farm Workers Who Did Not Follow the Crops North.

Shafer, James K. et. al.
1961 Health Needs of Seasonal Farm Workers and Their Families Public Health Reports 76, 6:469-474.

Steward, Judith
1968 An Examination of the Social Boundaries of the Migrant Labor System on the Atlantic Coast Stream; unpublished Masters' Thesis, Cornell University.

Suchman, E. A.
1965 Social Patterns of Illness and Medical Care. Journal of Health and Human Behavior 6:2-16

Warner, Lisa
1967 The Health of the Migrant in Eastern Suffolk County. Seasonal Employees in Agricultural Inc. Migrant Conference.

Watson, Goodwin
1969 Resistance to Change. In W. G. Bennis et. al. eds. The Planning of Change. New York, Holt, Rinehart and Winston, Inc.

LIFE STYLE OF MIGRANTS ON THE SEASON AND THEIR ADAPTATIONS TO COMMUNITY ATTITUDES

Ira E. Harrison, Ph.D., M.P.H.
Director
Division of Behavioral Science
Bureau of Planning, Evaluation and Research
Pennsylvania Department of Health

Paper Delivered at

The Florida International University Migrant Program's
Social Educator Workshop, Winter Park, Florida
February 15-17, 1972

LIFE STYLES OF MIGRANTS ON THE SEASON AND THEIR ADAPTATIONS TO COMMUNITY ATTITUDES

by Ira E. Harrison, Ph.D., M.P.H.

My thesis is simple. Migrants are marginal, and because they are marginal, providing services to them is frustrating, and we may need a new cooperative, coordinated single agency approach to the problems of agricultural migratory farm workers. Migrants are marginal due to their mobility, or lack of permanent residency, due to their unfavorable image, due to community neglect, and due to their adaptation to all of these. By marginal, I mean that they are economically peripheral, and socially tangential to the American main stream.

Migrants are poor marginal men, but very important marginal men. For example, the 1970 Annual Report of the Pennsylvania Migratory Labor Program Report states:

> "For the first time in history, Pennsylvania farmers received more than a billion dollars from the sale of their produce in 1969. Approximately 7,500 migrant farm workers in Pennsylvania helped to make this possible through their efforts in harvesting the fruits, vegetable, mushroom and tobacco crops produced during the year."

Migrants are probably more valuable to Florida than a mere billion dollars.

Each year over a million farm workers and their families leave their home counties to "go on the season." ("On the season" is these workers term for seasonal migratory farm worker.) These workers labor in over 700 of the nation's 3,100 counties, yet they are seldom seen. They are bussed and trucked through many communities at night to isolated farm camps. They are called migrants although many workers hate the name and would rather be known as pickers.

A migrant, or a picker, is an individual whose primary employment is in agriculture on a seasonal or temporary basis, and he or she

establishes residence for that purpose. There are three well-established migratory streams: The East Coast or Atlantic Stream, the Main or Mid-Continent Stream, and the West Coast Stream. The West Coast Stream is composed of mostly Mexican Americans, some blacks, Amerindians, and whites. California is its home base. The Mid-Continental, or main stream is composed predominantly of Mexican Americans, with some blacks, rural and Appalachian whites. Texas is the home base. The Atlantic, or East Coast Stream is comprised chiefly of blacks from the Southeastern States with some Puerto Ricans, Mexican Americans, and whites. Florida is the home base.

Because these agricultural nomads must follow the crops, wait for good weather, and be where the action is, they must be mobile. Mobility and the lack of residency means that they are not eligible, or miss out on public assistance, food stamps and commodities, normal schooling, adequate police, health and sanitary inspection and regulation. Migrants rarely vote. Statistics on migrants are difficult to obtain, because migrants are not counted in any official census. Using estimates and various migrant project data, we find that the migrant infant mortality rate is two and a half times that of the national average. Most of this results from such diseases as tuberculosis, influenza, pneumonia and other infectious diseases. Thus far in the 70's, the only reported epidemic of poliomyelitis occurred in Southern Texas where three migrant children died. In 1970, the life expectancy of the average American is about 72 years of life, while the life expectancy for the average migrant is only 49 years of life. Malnutrition is probably a major contributing cause for this low life expectancy. In a study I conducted on black migrants in the East Coast Stream, migrants' menus lacked vitamins A, B, C, and the milk and cheese group. This means that wounds and injuries seldom heal,

bones become brittle, tooth decay and rickets, scurvy, pellagra, and frequent gastro-intestinal problems occur. The average American pays about $300 a year for health services. Federal migrant health projects spend about $15 for each migrant. In 1970, the average migrant earned $887 for an average of 80 days of farm work. Educationally 80 percent of the migrant population never enter high school.

At the 1970 White House Conference on Food, Nutrition, and Health, Dr. Jean Mayer, Harvard nutritionist, summarized migrants' ability to obtain health and related services:

> "Migrant workers are an example of people who somehow fall between the cracks of existing programs. Their wives and their children could receive better care, better housing, and better education if they were on welfare. For continuing to work rather than receive welfare, they are 'fools, honorable fools, but fools.'"

Perhaps Dr. Mayer is overzealous in his indictment of the folly of migrants. I question whether or not most migrants know that they have welfare, as an option. He may be correct, that migrant might be able to do better on welfare.

Migrants are marginal because they have an unfavorable image. We studied community attitudes toward migrants by interviewing community officials (farmers, agricultural extension agents, clergymen, nurses, sanitarians, sheriff, etc.) in Florida, Virginia, Maryland, and Pennsylvania. Community attitudes were those of indifference, ignorance, and rejection of migrants. A few comments are:

> "I don't think that average beloved American citizen wants a damn thing to do with migrants."
>
> "Some of these people are just one jump out of the trees."
>
> "Migrants are what is left of the scum of the earth."
>
> "Niggers are like animals, you have to whip them or gun them into shape."

It is such comments that provide us with the following images and attitudes towards migrants in the East Coast Stream.

I. Image: Migrants are persona Non Grata

Attitude: they are undesirable people and one would not want to be associated with them.

II. Image: Migrants are Ne're Do Well

Attitude: You can not help them if you tried.

III. Image: Migrants are Niggers

Attitude: Even if you could help them, it would be useless because they are less than human.

IV. Image: Migrants are Troublemakers

Attitude: The migrant's life style is a montage of trouble, and their behavior ranges from a-social to criminal acts.

V. Image: The Migrants as Criminals

Attitude: Whatever happens to migrants, they brought it on themselves, and the community cannot be responsible.

VI. Image: The Migrants as Parasites

Attitude: The migrant exploits the community.

These community images of and attitudes toward migrants make it easy to see why communities neglect migrants, and why they are kept out of town as much as possible. In Pennsylvania, some migrant camps are so isolated that they are invisible from high elevation. That is, you seldom stumble into a migrant camp, you must be brought there, or you must know its location.

Most growers leave all management functions to the crew leader, and the crew leader is expected to keep his crews' contact with the

neighboring community to a minimum. This means that the crew leader not only supervises work, but he must also provide food, housing, transportation and recreation for his crew. As a result most migrants are forever in debt to the crew leader. The average migrant can earn from $7.66 to $25.00 a day depending upon the crop, his speed, the weather, and the market. (The average earning of Koos' worker was $6.22 in 1957, and $4.99 in a 1953 study.) During our study of migrants there were several slack (no work) periods in Virginia and Pennsylvania due to dips in the market price of crops, and the weather. However, the migrants were still fed, housed, and received their rations of liquor, cigarettes, etc. When work and wages were possible, the crew leader always took his money first, according to the records of debts on his books. Most migrants cannot read, or write, so they have to rely on the crew leader's word. The migrant is always credited enough food, shelter, cigarettes, liquor, and sexual favors to keep him in debt.

The crew leader has an unwholesome image in the mind of the general public, however, the crew leader is merely a broker between the grower and migrants. He can do what he does because the grower and the community permit and encourage crew leaders to isolate, and to exploit migrants. The crew leader becomes the fall guy.

Historically, the black crew leader was recruited by white ". . . managers and farm placement representatives in consultation with Negro ministers, civic leaders, local office personnel, and those who had been previously selected and were functioning as crew leaders." (Milton 1950:31) Crew leaders were given black and yellow arm bands of honor, posters and stickers for their cars and trucks, and business cards as indicators that they were surrogates of State employment agencies to organize local workers into crews. Black crew leaders arose as brokers

between local black workers who had lost the security of work under the sharecropping system.

The sharecropping system had replaced the slave-plantation system. Each system provided food, shelter and clothes; the bare essentials to dependent, powerless blacks. Blacks were dealt with in favors and credit. Blacks had little opportunity to get an education. A few of the accumulated affects of this is that few migrants can read, write, or tell time, and have little understanding of the value of money, pricing, or selective buying. Also they have had little, or no opportunity, to participate in community decision making processes in order to decide their own fate.

As a result of being mobile, of having highly undesirable images, and of being neglected, migrants have turned inward, and have adapted themselves to their marginality.

These agricultural nomads, or pickers, are marginal because they are isolated, and being isolated, they have adapted mechanisms of invisibility. That is, they have evolved mechanisms that keep them from standing out or being visible. For example, migrants use nicknames. Many are quite colorful: "Two-dollar man," "Trouble," "Jitterbug," "Black Knight," "Wolf," "Spaceman," "Preacher," but they protect one and conceal ones real identity. Moreover, outsiders trying to locate or to communicate with migrants frequently find them in the jook, or recreation hall with the juke box blaring away. The migrants move and behave as if it, the juke box, is not there unless they are dancing. There is no attempt to turn it down for conversation. Finally, remaining on camp is another way of sustaining invisibility, as few migrants have transportation, and because they are not wanted in town.

Unpredictability and uncertainty pervade the migrant labor system.

The picker, or migrant, is totally unable to either control how much he earns, or to predict how much he will be able to save. His working depends on the weather, the crew leader, the grower, and the market. The picker has not control over these. As a result of isolation, invisibility, unpredictibility and uncertainty, some rather bizarre, and puzzling behavior occurs. For example, to the chagrin of some people, migrants gamble. Poor migrants gamble! This is an attempt for some migrants to maximize their life chances by playing cards, or shooting dice--to make it big, to take their kismet in their own hands to alter their own fate.

To the chagrin of some, migrants urinate and deficate in unusual places: in a man's hat, in the bull pen, or in the showers. It is sort of like Gulliver urinating on Queen Mabs's castle, or Gargantua drowning mobs of parsiens by urinating from the tower of Notre Dame. It is matter out of order, or matter out of place. In circumstances where one has so little control over one's external environment, one may have to find delight in controlling aspects of one's internal environment--urine and fecal matter. Moreover, on many camps, the grass is not cut regularly and there are few, if any, lights at night, and migrants, like many of us, are fearful of snakes, and the unknown. Therefore, the latrine becomes the most accessible vacant receptacle.

Finally marginality fosters various leveling techniques of reducing everybody to the same level, to preserve invisibility, so that they will not continue to face harm and humiliation from the larger community.

1. Drinking and sharing a bottle of wine, whiskey, or gin or sharing a cigarette.

This is a way that everyone can participate by contributing a nickel, or a dime, to buy a bottle or a pack of cigarettes and feel a sense of accomplishment, success, and pleasure.

The drinking of beer, wine, and whiskey together is a way migrants seek to control their environment and thus reduce unpredictability. It's a way of including newcomers in the crew, to reduce the unknown, and to find out what's new. It is picker's cocktail hour.

Sharing the bottle has its aesthetic and health as well as its social benefits. The drinking water in various camps may look, tast, and smell differently; however, one's wine and whiskey always looks and tastes the way its suppose to look and taste. Although migrants are frequently criticized for drinking, what they drink may be more sanitary than the water they are exposed to in many camps. Wine, whiskey, and beer can be drinking water; they can be a tranquilizer from the drab and dreary conditions in camps. And, the empty bottles are oftentimes used for urinals while traveling through hostile communities which refuse migrants hot food and a decent place to rest.

2. "Playing the Dozen's--making verbal sexual assaults on each others mother, grandmother, or sisters. If a picker tries to be smart and stand out from the crew, he may find that he has to defend his mother, grandmother, or sisters in a game called the dozens. He may be challenged verbally to exchange, and to parry sexual brick-bats about his female relatives until he cannot respond anymore, or is able to put down his challenges. This game is usually played in front of a group of onlookers and each players pride is at state.

3. Jokes and story telling.

Some migrants are great story tellers. The story and jokes they tell rival the Brer Rabbit Stories and Aesops Fables in the wit, wisdom, and humor.

4. Bickering relationships and maybe knivings, slashings, a ritualized cutting. Migrants usually slash, rather than stab. When you want to kill someone, you stab them, not slash them.

These leveling mechanisms are used to maintain social control among a group of people in very, very, tense circumstances where there is very little privacy, very little escape, and very limited social contact.

Many camps are communities of mistrust and suspicion, and lack effective leadership to provide communication, organization and change. This leads to neglect of the body and the environment. There are complaints of aches and pains and mosquitoes and red flies and insecticides, but there is no one to listen, and no one to complain to. So soon, there are no longer complaints. Psychologists tell us that responses that are not reenforced soon become extinct. Therefore, some people think that migrants are happy, or immune to insecticides. However, skin rash, eczema, diarrhea, etc., all become occupationally and functionally accepted.

So much for the migrant and his adaptation to his marginal status, what about those who seek to provide services for migrants.

Most providers of services to migrants live and work in non-migrant communities and derive few satisfactions from servicing migrants.

Physicians and nurses say that migrants are poor patients. Physicians say that migrants do not follow instructions, seldom come for medical care until it is a crisis, and seldom have money to pay for the services. Nurses complain that migrants do not return for follow-up care. They complain that it is frustrating doing band aid health care where health education, nutritional and sanitarians' services could prevent many of the wounds and diseases they treat.

Teachers say that migrants are poor students. That is, they do not come to school regularly, and do not perform as well as other students perform.

Social workers and OEO personnel state that if migrants would leave

that wine and whiskey alone, they might be able to help migrants.

All of these workers with migrants are saying that migrants are poor material because they do not make me look good. They render my knowledge, tools, and techniques useless! The migrant as a patient seldom fully recovers, he may die; the migrant as a student seldom graduates from school, he may drop out; and the migrant as a client seldom settles down, and becomes a citizen, he may return to the stream, or end up in jail. Thus, those who work with migrants experience frustration and defeat rather than self-fulfillment and success. This will continue as long as there is a piece-meal provision of services. By piece-meal I mean that one agency provides day care to migrants, another pre-school, another grade school, another adult education, another health care, another welfare, still another job training, etc., etc., etc. Such an approach can be confusing for even a non-migrant.

In talking to those who try to deliver services to migrants, I get the feeling that they are not too familiar with the life styles of migrants and soon become overwhelmed by the problems they face trying to provide adequate, decent, and optimum care for migrants. As a result they become afflicted with a disease I call migrant withdrawal. They become so "smashed" by their inability to deal with migrants and their problems that they turn off and withdraw. Thus, there is great turnover in staff.

Still others employed in various migrant projects become rather cavalier, callous, and cynical in their attitudes towards trying to do something for migrants--realizing that they are doing little or nothing to alter the plight of migrants. This results in an erosion in morale, and a weaking in esprit de corps, which may be passed on to migrants as hostility, or rejection in the professional-client relationship. I

think that supervisors in piece-meal approaches to migrant problems ought to expect low job satisfaction among staff and to prepare for it, and few successes in rehabilitation.

Based on my research, I have divised a typology of migrants. (See Table 1: Migrant Typology and Chances of Rehabilitation in Traditional Piece Meal Migrant Projects.) This is not based on a random or representative sample, only ethnographic data. However, it may give us some idea as to why our piece-meal attempts to retrain and move migrants into the main stream fail. In essence, the crew leader is a better ethnographer and psychologist than most migrant program personnel. He knows what his people are like, he knows their wants and can provide it, and he has the greater community's support if only through their neglect. Thus, change in the migrant stream is really the out crew leadering of the crew leader. Schools, clinics, welfare offices, and training projects are competing with crew leaders and their supporters and are comming out second best.

If we decide that migrants are important, we may need a coordinated single agency--The Atlantic East Coast Migrant Stream Rehabilitation Agency, or something else to deal with the education, medical, counselling, retraining, rehabilitative, housing, and other problems of agricultural migratory farm workers in our post-industrial society. If there is a fault, or a flaw, it is with us, not with the migrants because there is more wealth, intelligence, and beauty in this room than I have seen in any migrant camp.

Some say that the solution to the migrant's plight is to do away with the migrant stream. Mechanization is doing this; however, attempts to prepare migrants for mechanization and non-farm jobs have not been too successful. Perhaps, instead of trying to make migrants self starters, and to move them into the main stream by adult basic education programs

Migrant Typology and Chances of Rehabilitation in Traditional Piece Meal Migrant Projects

Type	Orientation to the Stream	Orientation to the Crew Leader	Chances of Rehabilitation
1. Wino	Solace and source of wine	Provider of wine, food, and shelter as long as the wino can work in the field.	poor to fair
2. Ex-Con (Escapes from Southern prison farms)	Sanctuary and asylum	Protector from the outside world, and provider of essentials, as long as ex-con work in the field.	poor to fair
3. OAl's (old and infirmed)	Last hope for work	Protector as long as they can go to the field.	poor to fair
4. Drifters (Drop-outs)	Temporary resting place until they can get themselves together	Temporary employee to tolerate until they can do better	fair to good
5. Pro's (good pickers)	Work place--the stream is his world and he knows his way around camps, and crew leaders	Employer	fair to good; especially if related to agriculture
6. Crew Leader's Kin	They are learning the trade and keeping the business in the family	Kin, and view the crew leader as a teacher of the trade.	poor to fair
7. Prostitutes: Male, sissies Females, whores	A place to turn tricks for pay and pleasures	Protectors and providers of contacts.	poor to fair

and job training programs, we ought to see that migrants get special protection as federal citizen and are guaranteed decent housing, nutritious meals, and decent clothing. If farmers and agri-businessmen are subsidize, why not migrants? As a severly abused and exploited group of people, it may be that a lot of migrants are not suitable for massive efficient retraining schemes. They may have been all used up.

Some say that labor organizations may be the answer. I do not know, but it seems to me that in a post-industrial age, where the service sector is the fact test growing sector, organized labor would be more interested in organizing white collar workers and professions, rather than migrant workers. Beside farm workers are excluded from the National Labor Relations Act, and this makes it very difficult for labor to organize farm workers. Perhaps we will learn more about this from the speaker from the U.S. Department of Labor.

From my perspective as an anthropologist and a behavioral scientist, piece meal migrant projects are passe. I find that I am not alone in my thinking. In 1961, a sociologist and a public health educator in a Palm Beach County migrant health project wrote: "Observation and experiences during this project suggest strongly that the problems faced by migrant farm workers do not lend themselves to solution if they are treated only in part according to the interests and responsibilities of govermental and/or private organizations. The problems of migrant farm workers are not a health problem; not a labor problem; not a welfare problem, nor an agricultural problem. They are social problems, sufficiently complex to tax the very best resources available to any community, state or organization. Without consolidation of effort directed at the basic causes of the problems, it is probably more accurate to speak in terms of alleviating rather than solving the problem which the phenomenon of migratory agricultural labor brings to our attention." (Browning and Northcutt, 1961:65)

SOURCES

1. Annual Report of Pennsylvania Migratory Labor Program
   1970, Governor's Committee on Migratory Labor, Department of Labor and Industry, Harrisburg, Pennsylvania.

2. Browning, R. H. and Northcutt, T. J.
   1951, On The Season; Florida State Board of Health, Monograph No. 2.

3. Bryce-Laporte, Roy Simon
   1969, The American Slave Plantation and Our Heritage of Communal Deprivation; American Behavioral Scientist. 12:2-9.

4. Harrison, Ira E.
   1970, The Pickers: Migratory Agicultural Farm Workers' Attitudes Toward Health. Division of Behavioral Science, Pennsylvania Department of Health, the Pennsylvania Health Council, Inc., in cooperation with the U.S. Public Health Service, Harrisburg, The Pennsylvania Department of Health.

5. Health Fact Sheet: Migratory Agricultural Workers
   1971, Office for Special Concerns OS/ASPE, Rickville.

6. Koos, Earl L.
   1957, They Follow The Sun; Florida State Board of Health, Jacksonvile, Florida, Health Monograph No. 1.

7. Milton, A. V.
   1950, Citation of Merit for a Job Well Done; Employment Security Review (17) 31-35.

8. Nelkin, Dorothy
   1969, Aspects of the Migrant Labor System; New York State School of Industrial and Labor Relations, Cornell University, Ithaca, New York.

   1969, A Response to Marginality: The Case of the Migrant Farm Workers; The British Journal of Sociology, December (xx) 4:375-389.

   1970, Unpredictability and Life Style in a Migrant Labor Camp; Social Problems 17 (4) 472-487.

9. Pierce, James M.
   1970, The Condition of Farm Workers and Small Farmers in 1970; Report of the National Board of National Sharecroppers Fund, New York: National Sharecropper Fund.

10. Schriber, Martin E.
    1970, The Migrant Worker; The American Benedictine Review, (XXI) 1 56-78.

11. Schulman, Sam
    1968, The Future of Migrants; Eastern States Migrant Health Conference, Orlando, Florida, March 26-28.

12. Scott, Clarrissa
    1967, Those Who Remained: A Study of Seasonal Farm Workers Who Did Not Follow The Camps North, Mimeographed.